		1 - State RegistrarAmeno# s25.27.P	State of Maryland	•	ent of Health and cate of Death		eg. No. 17 17 2	3. Time of Death
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Fidencia	Walker				3 , 2008 Yea	
Examin		4a. Facility Name (If not institution, give s Prince George M	treet and number) edical Cent		City, Town, or Location of De Cheverly	ath	4c. County of De	e George's
Funeral Director		302-30-0707	7. Age (In yrs. la 93	Yrs. If U	Inder 1 Year If Under 24 Hours Mi		9. E -1914 P	Sirthplace (State or Foreign Country) uerto Rico
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince G		, Town or Location				10d. Inside City Limit:
3a or 28	I Direc	10e. Street and Number 5705 Misty Driv	e	10	f. Zip Code 20706	1	0g. Citizen of What US	
within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show ha Medical Examinar must ke multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moroced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Decedent of Hispanic Origin? specify Cuban, Mexican, Pures es 2 No Specify: Puerto R		14. Race - Ar Black, W	merican Indian, hite, etc. White
d within 72 ho giene. Ir than "natur The Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give kind o	Usual Occupation of work done during most of w DT use retired) emaker	rorking	16b. Kind of Busines	-
should be filed and Mental Hygid a marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Saturnino Walke	r			ame (First, Middle, I Garcia	Maiden Sumame)	
nd 2 shoulth and Malth and		19a. Informant's Name/Relationship (Ty) Elba Davis/Daug		19b. Mailing Add 5705 Mi	dress (Street and Number or .sty Drive I	Rural Route Number anham, Mc	, City or Town, State 20706	e, Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation ☐ Other (Specify) 21. Signature of Juneral Service Licens	emove from State Mu	D44.14m	Cemetery 3	I FUNER	Puerto AL SERVI	CE, P.A
805 8 8		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death		Columbia E			Approximate Interval Between
Icate be executed //Medical Examiner site burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sound in the second i	Due to (or as a consequence to (or a))).	uence of):	Down Hood	7gr1		Onset and Death
ath certif ttending or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 ☐ Ecto	pic pregnancy er (specify)		23d. Date of Month	delivery Day Year
uires thet the de signed by the a id be detached f	by	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underly	ring cause given in Part I.			e to the cause of death? Probably 4 Denknow
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Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	ED/O	Othor	eath Check only or		Page 6.4
	lon: To	27. Manner of Death Taiwatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at	28d. Describe h	ence 6 □Other (S ow injury occurred Lat M	
or Attendition deat	Certification:	2 X Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuly - At he building, etc. (Specify	ome, farm, street, fa	actory, office	City or Tow	treet and Number of	Rural Route Number,
To the Hospital within 24 hours of To the Funeral I completely filled	Medical C		sician: To the best of my kno ner: On the basis of examinal and manner stated.			ice, and due to the o	ause(s) and manne	r as stated.
To th within To th	Me	29b. Signature and title of certifier	Brook	>	29c. License number		29d. Date signed (<i>M</i>	onth, Day, Year)
(3)		30. Name and address of serson who co j)r. Karen 1000KG	ompleted cause of death (Item	23a) (Type, Brint)			0785	7
Sta		31. Date filed (Month, Day, Year) MAD 0 4 2008	32. Registrar's Signa			<i>J</i>		

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Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 27. Manny Death 1 Matural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and little of certifier 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ien: artifica ctor, p		evaminer?		ath (Check only one)	
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Name and address Coerson who completed cause of death (Item 23a) (Type, Print)	To the comple	Me.		MI) 29c. License number 3,50 Z		2 26 24 200
the Telegrand Congression Water constitution Millarge Ma MINN	20	4	ob. Name and address person who completed cause of death (Item 23a) (Ty	(pe. Print)	M. Ilore	willa MINZIN

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:25 P M 2008 MELVILLE LEAF WOLFE **FEB** 27, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **KENT** CHESTER RIVER MANOR CHESTERTOWN If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 066-01-0095 92 11/25/1915 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Items 23a or 28a-f shoviner must be notified at 1 X Yes 2 ☐ No Director MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ss 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, th. M-dical Examiner must be not the traumatic event, the M-dical Examiner must be not also as the content of the content of the model. 306 CEDAR ST. 21620 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No WWII & If yes, Give Year or Dates: KOREA 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No WHITE Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SHIPPING AGENT MARINE SHIPPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I SMALLWOOD LEAF WOLFE ဥ PEARLE CASSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE A. WOLFE/WIFE 306 CEDAR ST. CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 2/28/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final teriosclerotic ordrovos actor Physician Tyarrs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsequence off: Examiner that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an has 1∐ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred af or Attending Patter death. Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 29a. Certifier 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mo 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 Woshing to Kess m?

State

31. Date filed (Month, Day, Year)

2008

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 2008^{Year} Month 2 Mary Margaret Yager 25 <u>15:15</u>p[™] 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days 2/17/1926 Hours 1 □ M 2 🛣 F 577-30-6286 82 WashingtonDC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No MD Prince Georges Fort Washington 10g, Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20744 1221 Swan Harbour Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XNo Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Federal Govt. College (1-4or 5+) Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Thelma Marie Savoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20744 1221 Harbour Circle, Ft. Washington, MD Robert Yager/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Denation 15 □ Other (1 netery, crematory or other place Olivet Cem. 3 ☐Removal from State Mt. 2/29/08 Washington, DC √5 ☐ Other (Specify) 21. Signature of uneral Serv 22. Name and Address of Facility 420 H Street NE BK Henry Funeral Chapel Wash, DC 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of) Atherosclerotic cardiovascular disease years Se mentially list conditions Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown

Physician /Medical Examiner

be executed

Box 68760,

P.O.

Division or Vital Records.

death.

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

To the I

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be in

Maryland 21215-0036

Baltimore,

Director

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Certification;

Medical

and attending physician for use as the buria Physician/Medical ed by the a signed by t has certificate director,

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

2/25/08

autopsy perform 2 No 26. Place of Death (Check only one)

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Death 2 ER/Outpatient 3 DOA 1 npatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D19431

30. Name and address of person tho completed cause of death (Item 23a) (Type, Print)

Frank Ryan, MD 11701 Livingston RD #103 Ft. Washington MD 20744 31. Date filed (Month, Day, Year) MAR 0 4 2008

State Registrar 32. Registrar's Signature

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 03 Myrtle Anna Yaw acility Name (If not Institution, give street and number) Town, or Location of Death 4c. County of Death tospico atalis NICOMICO 5. Social Security Number If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 1□M 2XF Months Davs Hours Min 220-28-0433 -2 - 1933New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27859 Clearwater Court USA 14. Race - American Indian, 21801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No 1956 — If Yes, Give Year or Dates: 1958 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 1958 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Utilities 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Malley Luretta Hunkapiller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Yaw - husband 27859 Clearwater Court, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 3-1-2008 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) netestatic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ 24a. Was an autopsy 1 Yes (Check only one) 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or 7

permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. "natural", or Items 23ar Important: If Item 27 is marked other than "natural", or Items 23ar any Injury or other traumatic event, the Medical Examiner must b once.

Baltimóre, Máryland 21215-0036

Director

Funeral

Completed by

Be

Examine attending physician and for use as the burial-trar ed by the detached sate has been signed page 2 should be det certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be Medical Certification: To

25. Was ca examin 1 ☐ Ye

se referred to medical			26. Place of Dea	th (Check only one)
No	Hospital: 1 Impatient 2	ER/Outpatient 3 🗆 🛭	OOA Other: 4 Nursing H	ome 5 Residence 6 Other
o Death ural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred

27. Mapner o Death Natural 5 ☐ Pending investigation 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Signa	ture and	title of cer	tifier		\sim
/		100	//	5	//	
		14			18	1

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vear 2008

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryla		rtment of F tificate of	lealth and N Death		giene Reg. No.	2000	00506
	T C	à	Decedent's Name (First, Middle)	, Last)					2. Date of De	ath	2000	3. Time of Death
ſ	Physicia		Ronald Dale	Acker					Month March	Day	Year 2008	1:18 A. M
46	/Medic Examin		4a. Facility Name (If not institution		number)		4b. City, Town, o	r Location of Death			County of Death	1.10 21.
	EXAMINIT	er	1402 Illinois		,			Severn			Anne A	runde1
	Funeral	-5	5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth		ace (State or Foreign try)
	Director		212-34-1443	1 ∑ M 2□ F	66	Yrs.	Months Days	Hours Min.	Mar. 2		941 Mich	igan
	to be Made		Usual Residence of Decedent	-					11.01	, .,		
	yland how at	.	10a. State 10b. County		10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	a-fsl	ફ	Maryland Ann	e Arunde	1	Sev	ern					1 □ Yes 2√√No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Coun	try?
	th wil		1402 Illinois	Ave.			21144			Uni	ited Sta	tes
	dear sms	Funeral	11. Marital Status	Armed	ecedent Ever in Forces? 10	U.S. 13. \	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No	o- 1	 Race - Americ Black, White, 	
9	after or ite mine		1 ☐ Never Married 2 Marr	ed 1 Y Ye	s 2□No 19. Give 19	J	l∐Yes 2√√∑xNo	Specify:			Specify: Whi	
5-0036	ours ral"; Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:		2121					
,	72 h 'natu dical	Completed	15. Decedent (Specify only highest		d)	1 (Give	lent's Usual Occup kind of work done	during most of wor	king	16b. Kin 	d of Business/Ind	dustry
2121	rithin ne. e Me	du	Elementary/Secondary (0-12)	College	(1-4or 5+)	1	DO NOT use retired k Driver	a)		Tr	ansport	ation
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at		12	(77777	18. Mother's Nam	o /Eirot Middle			
	a a a	Be	17. Father's Name (First, Middle,	Last)					•	, maiden c	ourname)	
<u>Ş</u>	should be filed ind Mental Hygi marked other umatic event, ti	ို	Paul Acker				(0)		h Rich	011	T 0 7	2 ()
Maryland	l 2 sh n and ris n		19a. Informant's Name/Relations Mrs. Sheila Ack				•	and Number or Ru S Ave. Se			10wn, State, Zip 144	Code)
	es 1 and 2 should bot Health and Ment iftem 27 is marked rother traumatic			er / wir			sition (Name of				cation - City or To	wn State
altimore,	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal fro	m State	cemetery, crer	natory or other plac	1	h 17,		,	
Ē	. Ра tmen tant: jury		4 Donation 5 Dother (S		Me		ge Mem. I		800	Elkı	cidge, M	D
Bal	permit. Page Department of Important: If any Injury or once.		21. Signatur of Funeral Service	bay(K 4	. Name and Addre irkley-Ru 21 Crain	iss of Facility iddick Fu Hwy. S.E	neral H	ome E	Lė, MD 2	1061
r	4		23a. Part1. Enter the disease, or	complications tha	at caused the dea	ath. Do not ent	er the mode of dylr	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician	9 1	shock, or heart failure. List Immediate Cause (Final	of life of datase of	ii eacii iiie.		1 UNG	cauc	en			Onset and Death
)	/Medical	7	disease or condition resulting in death)	a	to (or as a conse			Coole				9111031
4-	Examiner											
Į.		je	Sequentially list conditions, if any, leading to immediate	Due Due	to (or as a conse	equence of):						
υþ	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c								
o,	an an rial-tr		resulting in death) Last	Due	to (or as a conse	equence of):						
8760,	cate be executed physician and the burial-transit	dical		d								
9		Medi		1							1	
. Box	death certifi e attending I d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome pf preg re birth 2□Fe		Ectopic pregnanc	v		2	3d. Date of delive	•
	0 0 0	icia	in the past 12 months? $1 \square \text{ Yes} 2 \square \text{ No}$	4□Pre	egnant at time of		Other (specify)	у			Month	Day Year
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ώ.	The law requires that the de ate has been signed by the a bage 2 should be detached i	by P	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	nderlying cause giv	en in Part I.			se contribute to t	he cause of death?
ë	w require been sig should b	b							123	Yes 2	□ No 3 □ Prob	ably 4 □Unknown
Records,	s bee	Completed							24a. Was		24b. Were auto	psy findings available
	The fav e has age 2:	E							_ perf	opsy formed? 2 No	death?	mpletion of cause of 2□ No
Vital	Physician: The la r this certificate ha ral director, page 2		25. Was case referred to medica					26. Place of Dea	1 Yes	- ()	1 163	20140
>	s cer	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	☐ Inpatient 2	☐ ER/Outpatier	t 3 DOA Oth	or:	1 -		3 ☐Other (Specia	fv)
Division or	y Physer this eral of	-	27. Manner of Death	28a. Da	ate of Injury	28b. Time o			28d. Describe			,,
O	nding th. : Afte	ţi	1 Natural 5 □ Pendin 2 □ Accident investi	9 '	ionth, Day Year)	Injury		rk? Yes 2∐No				
18	Atter	fica	3 ☐ Suicide 6 ☐ Could I	ined Zot. Fit	ace of injury - At	home, farm, str	eet, factory, office				d Number or Run	al Route Number,
á	after Direction of the ball of	Certification:	4 ☐ Homicide	bu	ilding, etc. (Spe	сіту)			City or 10	ówn, State,	,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.		(Check only 2 Medical	Examiner: On the	e basis of exami	nowledge, deat nation and/or in	n occurred at the ti	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) e, date and	and manner as s I place, and due t	stated. o the cause(s)
	the I	Medical	one) 29b. Signature and title of certifie		nanner stated.		29c. Licens	se number	ĺ	29d Det	e signed (Month,	Day, Year)
	Mil Vil	-		mil	(12)			10070	×		10110	000
)			7.7		J			11000		21	13912	008
	10		30. Name and address of person		ause of death (Ite	em 23a) (Type,	Print) 900	Bestaget	P Rd.	AV	napoli	5, Wd.
	Sta	te	31. Date filed (Month, Day, Year)	32	2. He gistrar's Sig	nature	lack:	7 4	- 1 (
	Registr	ar	制造尺 丁	7 2008	A DECAR	AS M	AND AND					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) nay 5:02 PM March war 17 7008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Mary lavo timor 0 8. Date of Birth (Month, Day, NOV, 20 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Min 1**∆**M 2□ F 216-50-170. TARYLAND Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 □ No MARYLAND Og. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify. Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EXINGTON HIGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) APT 210/BALTO MD 21223 0415E WATS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation 22. Name and Address of acility 21. Signature Funeral Service Licenses Oa MD 21217 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Tispase VEIOSCREIO disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 2 🗌 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

g/g

physician

attending

peen

this certificate has

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23a or 28a-f shov dical Examiner must be notified at

traumatic event, the Medical

other than

is marked

Mental Hygiene.

and

permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 is
any injury or other trau

Director

Funeral

þ

Completed

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

21215-0036

Baltimore, Maryland

Examine burial-transit the as signed by the atter Completed page 2: Be To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral (

The law requires that the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

Physician/Medical þ

Certification:

Medical

IF FEMALE 23b. Was decedent pregnant

25. Was case referred to medical examiner?
1 ☑ es 2 ☑ No

5 Pending investigation

6 Could not be

27. Manner of Death

1 Natural

2 Accident

3 Suicide 4 Homicide 1 Yes 2 No 3 Probably 4 Hinknown

24a. Was an autopsy perform 1☐ Yes 2 1000 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a Date of Injury 28b Time of 28d. Describe how injury occurred

28c. Injury at Work? (Month, Day Year) 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

17525

2008

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. Greenest, Baltimore Samantha MD 22

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			ype or Print in B						gible.	
		1 _ State	Otate of Marylane		tificate of L			Reg. No.	2036	
	-1	Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
Physicia		Antoinette M. Brazi	11				March	13 Day	2008	12:20PM
/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or		i rancer		unty of Death	
LAGIIIII	- S	Franklin Square H	tospital cen	ter	Ro	sedale		1:	salti	more
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th v. Year)	Cou	place (State or Foreign
Director		214-24-5646	M 2X F 79	Yrs.	Michinis Duys	Tiodis Iviii.	12-07-	1928	Mary	land
pu »		Usual Residence of Decedent 10a, State 10b, County	10c. City.	Town or Loc	cation					10d. Inside City Limits
shored at	5			nite Ma						1 □Yes 2 No
the N 28a-1 notiffi	Director	Maryland Baltimore 10e. Street and Number	WI	iice m	10f. Zip Code			10g. Citizer	of What Cou	ntry?
with Ba or t be		5209 Bush Street			2116	2		11 0	S.A.	
ns 2%	Funeral		2. Was Decedent Ever in U.S	5. 13. V	Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No		Race - Ameri	
after o		1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		f Yes, specify Cuba □ Yes 2 X No	n, мехісап, Риепо Specify:	Hican, etc.)		Black, White,	
ral", c	by	3X Widowed 4 ☐ Divorced	Year or Dates:		1 1es 201140	эреспу.		Sp	ecify: Whi	te
72 h 'natu dical	Completed	15. Decedent's Educa (Specify only highest grade		(Give	lent's Usual Occupa kind of work done o	luring most of work	king	16b. Kind	of Business/Ir	dustry
vithin ne. han '	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	Cler:	00 NOT use retired ical)		R1116	Cross	Blue Shield
iled v Hygie ther t nt, th		17. Father's Name (First, Middle, Last)		OICI	Tear	18. Mother's Name	e (First, Middle			Dide Billera
d be fantail	o Be	Nicholas Pace				Anna Ma			,	
should nd Me mark mati	ıĔ.	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailin	g Address (Street a			er, City or To	own, State, Zi	p Code)
nd 2 alth ar 27 is r trau		Anne Marie Niemczyk	(daughter)	2223	Westmins	ter Mano	r Lane	Sun Ci	ity, FI	33573
s 1 a if Hea item othe		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other plac		Date	20c. Locat	ion - City or T	own, State
Page nent c int: If		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	-	em. Garde	1	7-2008	Bel A	Air, Ma	ryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Foneral Service Licenses	е	22	. Name and Addres	ss of FacilitySch	imunek	Funera	1 Home	Inc.
89 2 2 8		Little		9	705 Belai	r Rd Bal	timore,	_MD_21		
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death e souse on each line.	. Do not ente				rrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Himary 1	5.110	ry C	irrhos	515			Onset and Dodge
/Medical Examiner		resulting in death)	Due to (or as a nsequ	ence of):	O					
4.4	<u></u>	Sequentially list conditions, b.	Due to for as a consequ	ence ofi:					-	
nsit	xaminer	cause. Enter Underlying Cause (Disease or injury								
executed n and ial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):						
	ca	d.								
tificat ig phy as th	ledi									
th cer endin r use	N/UE	23b. Was decedent pregnant	Bc. If yes, outcome pf pregna 1☐Live birth 2☐Fetal		Ectopic pregnancy	,		230	I. Date of deliv	<u>.</u>
e dea	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown		Other (specify)				Month	Day Year
nat thu d by t etach	Phy	9 Unknown Part II. Other significant conditions cont	tributing to doath but not recu	Iting in the ur	aderlying cause give	on in Part I	23e Did	tohacco use	contribute to	the cause of death?
ires the	þ	SI Canto Coccus	Agalact:	2	clare on	on in rait i.		Yes 2		bably 4 Unknown
requ been	Completed	SFIEDTO COCKAS	Agalactiae Renalfaile	109	CTCI CINI	4				
e law has b je 2 s	Jd II	Sepsis, Heute	Kenal tail	156	ynem.	9	24a. Was		prior to c death?	opsy findings available ompletion of cause of
Th. Th icate r, pag		Pulmonary hy	pertension	•			1□ Yes	2 No	1 ☐ Yes	2 No
sicial certif	Be c	Was case referred to m-dical examiner?	ospital: Minpatient 2□I	ER/Outpatien	nt 3□ DOA Oth	26. Place of Deat er:			704 (0	2E.A
Phy er this eral di	- T	27. Manner of Death	28a. Date of Injury	28b. Time of			ome 5 ☐ Res 28d. Describe			ny)
ding h. Afte fune	tion	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □No				
Atter rr dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify		eet, factory, office			(Street and I	lumber or Ru	ral Route Number,
s a e a le line	Certification:		January, stor (Speen)	,			0.1, 0.1.0	,		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	edical	(Check only 2 Medical Examin	ician: To the best of my knowner: On the basis of examinat							
the hin 24 the F	Medi	one)	and manner stated.		29c. Licens	e number		20d Data	signed (Month	Day Vaar
7 × × i		29b. Signature and title of certifier	& mil							
	- 9	Chrisen	DIMD	00-) (T	11156	581		Mar	ch 1	5, 2008
13		30. Name and address of person who cor	miller did cause of death (Item	23a) (Type,	con Ill'in	WILLIAM P	20,000	mil:	nore .	3, 2008 MD, 21237
Sta	ate	D. Tose phin Own: 31. Date filed (Mary 1904) Years 200	32 Registrar's Signal	tre /	anni	yvale 1	mive,	WITI	1	111,01001
Registr		MINU T 1 500	The marine of	100	A. A. C.					

DHMH 17 Rev 1/2001

State Registrar

		For State	State o	f Marylan		ertificate of L		/lental Hy	1	000	0.0	s n o
		Registrar 1. Decedent's Name (First, Middle,	(ast)			Timeate of L	Jean	2. Date of De	Reg. No.	UUO	3. Time	of Death
Physic	ian		Lasty					Month	Day	Year		P M
/Medi		Mary P. Bavis 4a. Facility Name (If not institution.	give street and nu	mher)		4b. City. Town. or	Location of Death	03-13-		County of Deat	<u> 540</u>	r
Exami	ner	Gilchrist Cente	•	inder)		Towson	EDUCATION OF BOARS			ltimor		
			6. Sex	7. Age (In yrs.	last birthday		If Under 24 Hrs.	8. Date of Bi	rth	9. Birtl	hplace (State	or Foreian
Funeral Director		220-01-4535	1 □ M 2 🂢 F	88	Yrs.	Months Days	Hours Min.	(Month, Di		Co.	untry) yland	
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ylanc ylanc		10a. State 10b. County		10c. City	y, Town or I	ocation			_		10d. Inside (City Limits
Mar Fied	ţ	Maryland Balt:	imore	G	len A	rm					1 □Ye	s 2X No
n the	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	untry?	
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ING 21213-UU35 be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span Mexican Puerl	pecify Yes or N	o- 1	4. Race - Ame Black, White		
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	Be	17. Father's Name (First, Middle, L	•					,		surname)		
faryland 2 should be t and Mental I Is marked of raumatic eve	2	Werner F. Schutt			1		Marie Mi					
Aar 2 sh 1 and 1 s m		19a. Informant's Name/Relationsh				lling Address (Street						000
	-	Karen Licharow	cz (Daug			320 Ross1a		Rd #50		ation - City or		093
altimore, mit. Pages 1 ar partment of Hea portant: If item: y injury or other		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 ☐Removal from	State 200. F	cemetery, cr	position (Name of rematory or other place	1		200. Loc	allon - City or	rown, State	
Page men tant:		4 ☐ Donation 5 ☐ Other (Sp		Du1	laney	Valley	03-1	7-2008	Ba1t	imore,	Maryla	and
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	icensee			22. Name and Addres	ss of Facility Sch	imunek	Funer	al Hom	e, Inc	
		Pleane	ueex			элоэ ветаз	ir ka bai	timore,	MD 2	21236		
		23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that only one cause on	caused the deat each line.	h. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Boundary	etween
Physician		Immediate Cause (Final disease or condition	DAV	wahi	CAM	w					Mont	
/Medical		resulting in death)	ue to	(or as a conseq		-						
Examiner		Sequentially list conditions	b. ———									
o (V =	Examiner	Sequentially list conditions, if any, leading to immediate Cause Disease or injury	Due to	(or as a conseq	uence of):							
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e exe	Ĕ	resulting in death) Last	Due to	(or as a conseq	uence of):							
cate be executed cohysician and the burial-transit	dical	,	d									
SOX 68 leath certifica attending ph	Mec	IF FEMALE:								·		
Box eath cert attending	an/	23b. Was decedent pregnant in the past 12 months?	1 □Live	itcome pf pregna birth 2 □ Feta	al death 3	□Ectopic pregnancy	/		2	3d. Date of del Month	ivery Day	Year
b dea he at he at	Sici	1 □Yes 2 👿 No	4□Preg 9□Unkr	nant at time of d nown	leath 5	☐ Other (specify) _				monar	Duy	7 0 0 1
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Aec e law r has be ge 2 sh	Completed							24a. Wa	s an opsy	24b. Were au	topsy finding	s available cause of
The ate h	E O							per 1∐ Yes	formed? 2 No	death? 1 ☐ Yes		
r Vital Hoysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?	000000000000000000000000000000000000000				26. Place of Dea	th (Check only	one)		2144	77
IF V nysic nis ce	일	1 Yes 2. No	Hospital: 1	Inpatient 2	ER/Outpati	ent 3 DOA Oth	er: 4 ☐ Nursing H	ome 5□Res	sidence 6	Other (Spe	city) WOSt	oile
On Ol ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time Injury		y at k?	28d. Describe	how injury	occurred		
JIVISION OF lor Attending Phys after death. Director: After this in by the funeral dir	atic	2 ☐ Accident investig	ation			M 1 🗆	Yes 2 □ No					
VISIC r Attender er death rector: by the r	Certification:	3 Suicide 6 Could n 4 Homicide determi	nod Zoe. Flaci	e of injury - At ho ling, etc. (Specif		street, factory, office		28f. Location City or To	(Street and own, State)	f Number or Ru	ural Route Nu	ımber,
Baft alo	Ce											
DIVISION OF VITAI RECORDS, P.O. BOX 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit				e best of my kno	owiedge, de	ath occurred at the ti-	me, date and place	e, and due to the	e cause(s)	and manner as	s stated.	e(s)
the H in 24 ihe F	Medical	one)	and mar	ner stated.				- 1		, , , , , , , ,		
To t To t	Σ	29b. Signature and title of certifier	i			29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)	-2
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17		30. Name and address of person	1 -	se of death (Iten	n 23a) (Typ	29c. Licens D. G. e, Print) Cum	/. 0			10 21	2	
10		HAMON 9.00	1.100.61	no 6	701	N. Chm	us Sr	TOWS	un n	W L	Ley	
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Regis	trar	MAR 1 7	2008	inchision of	S. A	parte "						
DHMH 17 Rev 1/	2001		135		-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day March 13,2008 **Physician** Michael Borrell 16:16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HArford Upper Chesapeake BelAir Md. Harford County if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Yea 9-17-1931 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Md. 216-28 -2341 77 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director Harford Street Md. Md. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 203 Holy Cross Road 21154 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other trainments. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melville Borrell Marjorie Egan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Borrell 203 Holy Cross Road Street Md. 21154 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley

22. Name and Address of Facility 3-17-2008 Timonium Md. 21. Signature of Funeral Service Licensee Schimunek Funeral 9705 Belair Rd. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) tarction **Physician** 60 minutes Ylyocardia /Medical Due to (or as a consequence of): **Examiner** oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit pertension Due to (or as a consequence of): holestera Physician/Medical C. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 ☐ Pregnant at time of death ed by the a detached f 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) e Hospital or Attending PI 24 hours after death. e Funeral Director: After the letely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the 1... within 24 hours a... To the Funeral D' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number

di

State Registrar 31. Date filed (Month, Day,

resappate Dr. Bel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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be notified Director		ry1and Street and Nu	Baltime mber	ore		King	sville 10f. Zip Cod	e		10g. Citize	en of What Co	1 □ Yes 🛣 No
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xaminer must by Funeral	1	Marital Status I XNever Mari 3	ried 2 Married	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:		5.	If Yes, specify C	of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	erto Rican, etc.)		Black, White	e, etc.
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ny Inji	21.	Signature of F	uneral Service Lice	nsee				Idress of Facility So D. W. MacPh				ne of BelAi
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neral d	07	was case fele examiner? 1 Yes 2 Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide		De 28e Place of in	ury ay Year) jury - At h	28b. Tin Inju		Other: 4 Nursing Injury at Work? 1 Yes 2 No		idence 6 how injury	occurred	ecify) Hospice
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comp	291	o. Signature an	d title of certifier	, nn	10 10	A 0.		cense number		29d. Date	signed (Mon	th, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death ay 10 **Physician** Benner Florence March 2008 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 07/08/ Birthplace (State or Foreign Country) Months **Funeral** Days 1 □ M 212 F 215-07-7244 Yrs. Director Maryland Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland minnant of Health and Mental Hygiene. orfant: If fen 27 is marked other than "naturel", or items 23a or 28a-f show injury or other treumstic event, the Medical Examiner must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits itams 23a or 28a-f sho ner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Maiden Choice Lane 21228 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, atc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes X☐ No Specify: Specify: White δ 3 Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Manfucaturing 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Conrad L. Laage Sarah F. Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Howard W. High (Son) 420 Shady Nook Avenue, Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State Department important: If 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 03/14/2008 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature di Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Mindian. Immediate Cause (Final disease or condition resulting in death) PREUMONI Examiner Examiner led by the attanding physician and datached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, paga 2 should be datac 1 ☐ Yes 2 ☐ No 3 Probably þ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 - Homicide To the Hospital 29a. Certifier edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jver 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SLON Rolling Rd Ste 35 Registrar's Signature 31. Dete filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 11, Charlotte M. Burk 2008 7:30 A^M March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Martin's Home Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foundry) | Min. | May 29, 1918 | Maryland Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□M 2▼F Months 89 Director 170-12-1170 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 601 Maiden Choice Lane permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 any Injury or other trainmetic. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: white 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Huldah Stahl Harry Kitting 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9608 Ninth Ave., Baltimore, MD 21234 Mary L. Manion / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 3/14/2008 Ownings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ens **Physician** /Medical Due to (or as sconsequence of): Examiner pertension cape initially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner be executed P.O. Box 68760 burial-tra Due to (or as a consequence of) attending physician for use as the buria use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed: 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide determined

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica hours after death.

Ineral Director: After this y filled in by the funeral di

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

March 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDAN Baltimor MD 2:229 EW. 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** prouks 08 ashti 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kan Hospice Inpatient Un alls Town -el Deasons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2√F 88 Director 220-24-7347 18 19 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show a or 28a-f sh 1X Yes 2 No MD NA Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 4035 Belle Ave 21215 U.S.A. Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify. Black If Yes, Give Year or Dates: X□ Widowed 4 □ Divorced r than "natur the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Social Security Adm. na Correspondence Analyst 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Singleton Valentine Helen Meredith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is Clyde Williams-Son 4035 Belle Ave, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Garrison Forest Vet 3/20/08 Owings Mills, Md permit. 21. Signature of Funeral Service Licensee Marchandropess of Facility 4300 Wabash Ave, Baltimore, 21215 Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Uterene Greno Celcerona /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Exami and / Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the should be detached 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 22 No page 2 s certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence On Other (Specify) Hopica Unit Medical Certification: To 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 12 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation after death | Director: / 2 Accident the 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I completely filled 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

iD

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

m.D

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28628

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	ryland /		rtment tificate			d Mer		giene Reg. No.?	008	0.8	516
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) John G. Bauer				4h Ciby T	OWD OF	Location of D	Ma	Date of Dea Month rch	14,	Year 2008 ounty of Death	3. Time of 1:4:	6
)	Examin Funeral		4a. Facility Name (If not institution, give s Gilchrist 5. Social Security Number 6. Sex	7. Age	(in yrs. last b	irthday)_	Tow If Under 1	son	If Under 24	Hrs. 8	Date of Birt (Month, Day)3/23/	h	Baltimo 9. Birthp	olace (State ntry)	or Foreigr
Region .	Director % ta		216-09-0310 Usual Residence of Decedent 10a. State 10b. County	, 91	10c. City, Tov	Yrs.	ation)3/23/	1916		yland 10d. Inside (City Limits
	ith the Man or 28a-f sh	Director	MD Baltin			Tows	10f. Zip					0	en of What Cou		2 X No
36	be filed within 72 hours after death with the Maryland ital Hygliene. id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral I	6451 N. Charles S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 DYes 2 No If Yes, Give Year or Dates:					spanic Origin n, Mexican, F Specify:	? (Specify Puerto Rica	Yes or No- an, etc.)	. 14	USA 1. Race - Americ Black, White, Specify: Whi	etc.	
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and 21	be d al	Be	12 17. Father's Name (<i>First, Middle, Last</i>) John Bauer			Bus	sines	SUW	18. Mother's	•	rst, Middle, Schee	Maiden S		mica i	
Maryland	is 1 and 2 should of Health and Men Item 27 is marke other traumatic	욘	19a. Informant's Name/Relationship (Ty) Bryron Hertslet							or Rural R	oute Numbe	er, City or	Town, State, Zij		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place	of Dispos ery, crem	ition (Nam atory or ot	e of	э)	Date -18-2		20c. Loca	ation - City or T Onium, N		
Balt	permit. Page Department of Important: if any Injury or once.		21. Signature of Funeral Service Licenson	Muc	w	10	050 Y	ork	Road,				neral H 204		
1	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		PICATION	NJ d			entri	rdiac or re	spiratory a	rrest,		Approxima Interval Be Onset and	etween I Death
1 8	ate be executed www.hysician and hurial-transit burial-transit	lical Examiner	Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a											
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal dea		Ectopic pre Other (spe					23	3d. Date of deliv	ery Day	Year
ecords, P.	iw requires that is been signed by should be detail	by	Part II. Other significant conditions cor	ntributing to death bu	t not resulting	in the un	derlying ca	use give	en in Part I.		23e. Did t	1	e contribute to No 3□ Pro		death?
r	The ate h page	Completed									24a. Was autor perfo 1∐ Yes		24b. Were aut prior to co death? 1 □ Yes	opsy finding ompletion of 2 \(\text{No} \)	
Division or Vital	ding Phy After this funeral d	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date of Injur (Month, Day	Year)	. Time of Injury	M 28	Bc. Injun Work	4 LI Nursi	ing Home	5 ☐ Reside :	dence 6 how injury			
	- 9		4 Homicide determined 29a. Certifier Certifying Physics	28e. Place of injurbuilding, etc. siclan: To the best of the control of the basis o	." (Specify) If my knowled	ge, death	occurred a	at the tin		place, and	City or Too	vn, State) cause(s) a		stated.	
	To the Hospital of within 24 hours aff To the Funeral D completely filled in	Medical	one)	and manner star	ted.		29c.	License	number			29d. Date	signed (Month	, Day, Year)	
			30. Name and address of person who co	ompleted cause of de	eath (Item 23a	(Type, F	Print)	DW SU	w mo	212	04		,		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Month 9:42 M Baver /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Year) Hours 1 M 2 □ F 214-11-9487 Director Maryland 15 Usual Residence of Decedent ia or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 X No Director MD Baltimore Lutherville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ", or items 23a c aminer must be 129 Tenbury Road 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No White Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Full Time Student permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dewitt Bauer Kathleen Cadden 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Bauer (Mother) 129 Tenbury Road, Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5▼Other(Specify) Entombment Oak Lawn Cemetery <u>03/1</u>7/2008 Baltimore, Maryland 21. Signature of Furer | Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2094 **Physician** SEVEYE -a11 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner vain death CERTIFICATION APPROVED BY MEDICAL EXAMINE Says ticily list or ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4□Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? 2 □ No 25. Was case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 12:55 AM Subject Fell OFF Balcony 09 2008 1 ☐ Yes 2 No I or Attend after death 2 Accident 3 ☐ Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) Emmitsburg, MD Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Schoo 16300 Old Emmitsburg Rd Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Implementation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, To the Hospital o within 24 hours aff To the Funeral D

> State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

nielle

2a

31. Date filed (Month, Day, Year)

MAR 1

DHMH 17 Rev 1/2001

29c. License number

S. Greene St. 2120

29d. Date signed (Month. Dav. Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** Ba 2000 9:55 13 M MALC /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Trome wood CIL 15al tomore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-22-57 1 M 2 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore MD 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Woodland Avenue ISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 3 Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurse Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (sebrairla ပ္ t's Name Relationship (Type. Print) 19b. Mailing Address (Street and Numbe) Rural Route Number, City of Town, State, Zip Code) Randalbtown MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐Removal from State 03.18.08 | Windsor Mill, MD King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Volumen C. Greene Funeral Sewices 21. Signature of Funeral Service Licenses 8728 Liberty Road Kandallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ylais /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of hijan) that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 687605 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic anemic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 146 1+ TH certificate has birector, page 2 s 24a. Was an autopsy performed decube tus 2 No director, 25. Was case referred to medical Be 26. Place eath Check onl one examiner? Other: ို 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 🗌 Yes 2 🗆 No 2 Accident Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1231295 3/12/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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/Medical		Kendell Javon				# 65 T-		of Dooth	March		08 unty of Death	11:09 AM
xaminer	ľ	la. Fecility Name (If not institution	-			4b. City, Town,		or Death			-	orge's
		Southern Mary 5. Social Security Number	Land Hosp	7. Age (In yrs.	last hirthday)	Clinto	r If Unde	r 24 Hrs.	8. Date of Bir	41-	9. Birth	place (State or Foreig
eral ctor		none	11 M 2□ F	7. Ago (m) 773.	Yrs.	Months Days		Min. 54	Mar 7,	y, Year) 2008	Mar	yland
OI.		Usual Residence of Decedent										
ě –		10a. State 10b. Count	у		ity, Town or Lo							10d. Inside City Limits
Director		DC			Washin	gton						1 ☐ Yes 21 No
ral Director	<u> </u>	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	ntry?
		523 46th Stre	et SE #4				20019				USA	Ladia
Funeral	au l	11. Marital Status	Armed	cedent Ever in U Forces?	J.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic C ban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White	
L	y Z	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes. (s 2 ∑ No Give		1 □ Yes 2X No	Specify	y:		Sp	ec <i>ify:</i> b]	lack
2	<u> </u>		nt's Education	Dates:	16a Decer	dent's Usual Occi	unation			16b. Kind	of Business/Ir	ndustry
Completed	lete	(Specify only high	est grade completed		(Give	kind of work done DO NOT use retir	e during mo	st of work	ing			··,
1	Ĕ	Elementary/Secondary (0-12) none	none	(1-4or 5+)	none		,			none	:	
0		17. Father's Name (First, Middle	, Last)				18. Mot	her's Name	e (First, Middle	, Maiden Su	mame)	
a	0	Michael	Ricardo B	lanchard	i		St	ephar	nie Ste	wart		
-		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route							al Route Numb	te Number, City or Town, State, Zip Code)		
-	1	Southern Mary	land Hosp	ital	/503	Surratt	s Koa	ia CI:	inton,	MD 20	1733	
once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 ☒ Other	3 □Removal from	m State	Place of Dispo cemetery, crei	osition (Name of matory or other pi	lace)	(Date	20c. Locat	ion - City or T	own, State
9		21. Signature of Funeral Service Ronald				2. Name and Add tate Ana				. Balt	imore	Street
a	1	23a. Part1. Enter the disease,	1// 1000	_	Ва	altimore	, MD	2120	01			Approximate
the burial transit of a call transit of the call transit of the call transition of the call	dical Examiner	shock, or heart/failure? Li Immediate Dause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	to (or as a conse	quence of):	179						Onset and Death
of Macinion	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Liv	outcome of pregi e birth 2 □ Fe egnant at time of known	tal death 3	⊒Ectopic pregnar ⊒ Other (specify)				230	d. Date of deli Month	very Day Year
40 74	by Pr	Part II. Other significant condi	tions contributing to	death but not re	esulting in the u	underlying cause (given in Par	t I.		tobacco use	/	the cause of death?
ofolow	Completed								24a. Waa auto perl 1 ☐ Yes	s an possy formed?	24b. Were au prior to death?	topsy findings availate completion of cause of
	ပိ	25. Was case referred to media	cal				26. Pla	ce of Deat	th (Check only			
0	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4	Nursing Ho	ome 5 Res	sidence 6 [Other (Spec	cify)
F	tion: T	27. Manner of Death 1 Natural 5 □ Pen	28a. Da	ite of Injury Ionth, Day Year)	28b. Time of Injury	of 28c. In	jury at /ork? □ Yes 2	□No	28d. Describe	how injury o	occurred	
3	Certification;	3 Suicide 6 □ Coul	d not be 28e. Pla	ace of Injury - At ilding, etc. (Spec		reet, factory, offic	ee			(Street and I own, State)	Number or Ru	ural Route Number,
	d)	/	ying Physician: To	the best of my ki	nowledge, dea nation and/or ir	th occurred at the	time, date y opinion, d	and place, leath occur	and due to the	e cause(s) ar e, date and p	nd manner as lace, and due	stated. to the cause(s)
		(Check only 2 Medic	al Examiner: On the	anner stated								
	Medical Ce	(Check only 2 Medic one)	al Examiner: On the and m	anner stated.		29c. Lice	nse numbe	r		29d. Date.	signed (Monti	h, Day, Year)
		(Check only 2 Medic	al Examiner: On the and m	anner stated.	 D,	29c. Lice	ense numbe	er O		29d. Date.	signed (Monti	h, Day, Year)
		(Check only 2 Medic one)	al Examiner: On the and m	enner stated.	₽,	D4	anse number 219	or D		29d. Date.	signed (Monti 67/2	h, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Physician 12:180 M CICN 2008 valieROS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ita uare tranklin Age (In yrs. last birthday)

90 Yrs. 8. Date of Birth (Month, Day, Y Security Number Birthplace (State or Foreign Country) **Funeral** Days Year) Hours 1 M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Pres 2 □ No Directo HMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 2122 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 100 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: WL, Fe Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balhmore DUNSE OR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 10 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) LIBBS IOINO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD emekky 21. Signature of Funeral Service Licensee 22. Name and Address of acility FUNERAL 34 Willow Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 5106 /Medical Due to (or as a consequence of) Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be execute. burial-transit and Die to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 TEctopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral vascular disease, 1 Yes 2 No 3 Probably 4 Vnknown 4bove Knee Amputation 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 00 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the Funeral Director: npletely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LES 00 March 2008

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) MAR 1 7

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 03-15-2008 **Physician** 810 A M Frederick V. Demski, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ▼ M 2 □ F Director 170-24-1739 09-28-1931 76 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Director Maryland Harford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 302 C Canterbury Rd Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: White er than "natural", of the Medical Exar 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telecom Operations Manager 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Robert L. Demski Bertha Siekelska 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 Is n 1707 Morning Brook Dr Forest Hill, MD 21050 Frederick Demski, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once, Gardens of Faith 03-19-2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service License 610 W. MacPhail Rd Bel Air, MD 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Con **Physician** enn /Medical Due to (or as a cons que nce of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examine burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined ō within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

10 State

FREDERICK

Registrar

29b. Signature and title of certifier

31. Date filed (Mariti Day Year) Zuuc

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A Registrar's Signature

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29c. License number

29d. Date signed (Month, Day, Year)

MArch 15, 2008

Box 68760,	
al Records, P.O	
or Vital	
Division	

			Please Type or Print in State of Maryl					_	ole.	
			For State Of Mary 1		rtificate of L			g. No	18	08523
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) DANIEL DIVELBISS				2. Date of Death Month March	D	800	3. Time of Death 5:55 PM
}	Examin		4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical (Center	4b. City, Town, or Towson	Location of Death		4c. County Baltin		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday, 65 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 1 1/8/19	Year)	9. Birth Mar y	place (State or Foreign
	e Maryland Ba-f show tified at	ctor	MD Baltimore	City, Town or L						1 ☐ Yes 2 ☑ No
	th with the 23a or 2 ast be no	Funeral Director	108 E. Susquehanna Ave.		10f. Zip Code 21286			USA		
326	should be filed within 72 hours after death with the Maryland of Mental Hygiene. Tradurally hygiene marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show maric event, the Me-iral Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2000No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - Ameri k, White, : Whi	
1215-0036	within 72 hou ene. than "natur a he Meural E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired Pict Sales	during most of work f)	ing	Keebler		dustry
Maryland 2	ed stal	To Be Co	17. Father's Name (First, Middle, Last) Ersel R. Divelbiss				te Hoffm	an		
	2 s		19a. Informant's Name/Relationship (Type. Print) David Divelbiss / Brother	I	ing Address <i>(Street a</i> 95 Southwe					
Baitimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other t once.		1 Neurice 2 Octomation 3 Demoval from State	cemetery, cre loreland	position (Name of ematory or other place Mem. Park	3/20	/2008 B		e, M	laryland
Bail	permit. Departi Import any inj	5 67	21. Signature of Funeral Service Licensee		22. Name and Addres		owson, M 1 Home,	aryland Inc. 10	1 212 050 Y	204 'ork Road
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	Examiner	Examiner	Sequentially list conditions, if any, leading to minisulate cause. Enter Underlying Cause (Disease or injury that initiated events	6 CA	V CER,	SMALL (ELL			1 month
68760,	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last Due to (or as a conduct of the conduct o	nsequence of):						
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_	ires this signed I be de	þ	Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying cause giv	en in Part I.	23e. Did tob	d tobacco use contribute to the cause of death? Ves 2 No 3 Probably 4 Unknown		
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or Vital	this	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatie		er: 4 🗆 Nursing H	th Check onl on one 5 Reside 28d. Describe ho	ence 6 ⊟Oth		ify)
Division or	ding h. After fune	Certification:	1	ear) Injury	M 1	rk? Yes 2 □ No				ral Route Number,
o C C	ospital or Attend hours after death uneral Director: ly filled in by the		4 Homicide determined 236. Flate of Injury 194 July 195 J	Specify)		me date and place	City or Town		anner as	stated
(,	P P P P P P P P P P P P P P P P P P P	Medical	(Check only 2 Medical Examiner: On the basis of examiner and manner stated.	amination and/or	investigation, in my	opinion, death occu	rred at the time, d	ate and place,	and due	to the cause(s)
)	To the within To the comple	2	29b. Signature and title of certifier		e, Print) CHAMES	2773	0	3/	15-/	P
			30. Name and address of person who completed cause of death	(Item 23a) (Type	e, Print) CHAMES	17.	BALTIM	ONE,	40	21204
ľ	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 7 2008 32. Registrar's	Signature 9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number **Examiner** arriage Hil 6. Sex If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Min. Days Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? ō rriage Hill 48A 23a Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 10, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Black "natural" Completed the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be les Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. circle, Randallstay Carriage 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn 4 □ Donation 5 □ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6 month disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ₩No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 **№** No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To nours after death. neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 D Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RICHARD Physician Month Day Year HENRY EKEROTH 03 2008 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CENTER WESTMINSTER CARROLL HOSPITAL If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Days Hours 75 Director 337-28-6483 July 20 1932 IllinoisUsual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at MD Carrol1 1 ☐ Yes 2 No Director Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1667 Gemini Drive 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married X Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: ò Specify: white Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bendix Corporation engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Oscar Ekeroth Estelle Hineman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecilia A. Ekeroth (spouse) 1667 Gemini Drive, Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 3-18-08 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD : 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PHELMONIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit that the death certificate be executed Due to (or as a consequence of) physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 2. No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 NInpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 은 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Naturel 2 Accident 5 ☐ Pending investigation Injury within 24 hours area co-1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

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Registrar

31. Date filed (Month, Day, Year)

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

KANL

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔁 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0058580

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** 6:30 PM Konald Lason MArch 8006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL Point VA MAMLAND HEALTH CARE SYSTEM PERRY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 137-50-0518 1 M 2 F Director New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ es 2 ☐ No lenn. Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or 7 Cardle Lane 1769 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: item 27 is marked other than "natural", or items 3 other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Accountan 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be 2 should be finand Mental H Willie Mae Keed Carnegie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Karen Sister Ave. Paterson 20c. Location - City or Town, State 07502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ō 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any Injury or once, larvian 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Zervice Licen-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx ate Interval Between Onset and Death deficiency Syndrome Immediate Cause (Final Due to as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): or Vital Records, P.O. Box 68760, The law requires that the death certificate be Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No 24a. Was an page 2 : perform certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🜠 🕽 🔾 🔾 2 ER/Outpatient 3 DOA Certification: To this the funeral 27. Manner of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title 29c. License number 20396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11

State Registrar Thanles Hoesch, VA Mary land
31. Date filed (Month, Day, Year)
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Known to Physician:

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Nealth Care System, Perry Point, MD 21902

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	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortent: if Item 27 is marked other than "netural", or Iteme 23a or 28a-f show injury or other traumatic avent, the Medical Exeminar must be notified at injury or other traumatic avent, the Medical Exeminar must be notified at	tor	md. NIA		Balti	more			1/2 Xes 2 □ No
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0, 4	Physician /Medical Examiner nutal-transit	i Examiner	23a. Fart. Enter the sease, or complic shock, or ear ailure. List only one immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		YOCARDI uence of): LEROTI uence of):	AL INFAR			Interval Between Onset and Death 2 1 do us
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	Hospi 4 hou Funer ely fill	Medical	(Check only 2 Medical Examin	icien: To the best of my knower: On the basis of examinat	wiedge death occurre	ad at the time, date and place on, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and menner as sta and place, and due to	ited the cause(s)
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Funeral Director

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Baltimore, Maryland 21215-0036

Physician /Medical Examiner

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Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending after death. within 24 hours at To the Funeral C n

State of Maryland / Department of Health and Mental Hygiene Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death MARCH 2008 ERNADINE BERTHA FEENEY 5:30 A. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner QUAIL RUN ASSISTED LIVING PARKVILLE BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Months Days 1 ☐ M 2 🖫 F Hours Min. 9/9/1914 214-03-3496 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2XNo Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1564 GLEN KEITH BLVD. 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify ģ Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED BEAUTICIAN 8TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 ERNEST B. LETTAU MARGARET BAHNINE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID FEENEY/GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 21015 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY CROSS CEMETERY 3/17/2008 | BROOKLYN PK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. THEROSCLEROTIL CARDIOVASCULAR DISEASE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) FYPER TENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ARKINSONS resulting in death) Last Due to (or as a consequence of) EPRESSION Physician/Medical IF FEMALE: 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) Markel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

A Belle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** 6:30 PM Gertrude Doris Foltzer March 14. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u> Genesis Eldercare - Heritage Center</u> Dundalk Baltimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/30/1920 Birthplace (State or Foreign Country) Age (In yrs. last birthday, Funeral Social Security Number 6 Sex Days Hours 1 M 2 XF Director 219-07-0988 87 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c_City, Town or Location 10d. Inside City Limits 1 TYes 2 XNo Director Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1560 Alconbury Road 21221 Funeral 5. A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by 3 XWidowed 4 ☐ Divorced Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James M. DeBaufre Hilda Lucy Fitzpatrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4059 Littletown Pike Westminster, Maryland 21158 Eva Marie Caple (Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/17 2608 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** TIVE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed e to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown à signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☑ No page 2 autopsy performe cate 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State

29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001 Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Deceda nt's Name (First, Middle, Last) 2. Date of Death 13, 2008 Month **Physician** ampson March 7:20 PM /Medical County of Death Baltimore 4b. City, Town, or Location of Death Examiner limonium 7. Age (In yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1□M 2**X**F Hours Director Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits Be Completed by Funeral Director 1 XYes 2 □ No Baltimore 10e. Street and Number 10g. Citizen of What Country? must be r 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) : If item 27 is marked other than "natural", or Items or other traumatic event, the Medical Examiner ma 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tie. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) t of Health and Mental Hygiene. If item 27 is marked other than moloveo 18. Mother's Name (First, Middle Maiden Surname) 17. Father's Name (First, Middle, ast) 2 y nor 19b. Mailing Address (Street and Number of Rural Royte Number, City or Town, State, Zip Code) 2. Wings Mills Place of Disposition (Name of cometer), crema ory or other place) 20a. Method of Disposition 1 MBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State Department of Important: If any injury or once. Funeral Services 23a. Part1. Entet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 27580059 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed use as the burial-trag Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)13500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM 31. Date fileds (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c. 22 per fb 98773-19-08 vt. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend #17 Per FH G879 5/09/68rt Heate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nanci NMI Frazier 2008 06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner senesis eknollwood Anne Millersville Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 KF Months Director Dec 27, 1954 Maryland Usual Residence of Decedent 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural" or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director MD 1 ☐ Yes 2√ No Anne Arundel Millersville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 899 Cecil Avenue 21108 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disablity 12 determination/SSA 17. Father's Name (First, Middle, Last)

Douglds Albert Frazier 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil I Health and Mental H tem 27 Is marked oth Be Ruth Hollingsworth ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trau Randy Frazier/brother 6523 Aden Lane Austin, TX 78739 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 3-17-08 Beltsville, Md. 4 □ Donation o M Other (Specify) in State LOHRMANN, P.A S Wad . Name and Addre SAFA STEPHEN_ D. Mil. Green astures Dr. 23a. Patt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DYSTROPHY Physician MYOTONIC LIFE LONG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical as the l attending IF FEMALE for use 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? 1 ☐ Yes 2 ☐ No perform 2**X** No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident Iniury 5 Pending n 24 hours after death.

The Funeral Director; A pletely filled in by the funeral pletely filled in death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) To the within 2 the 29b. Signature and the of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KICBRIDE RD BATIMORE, MID 21236 C 32. Registrar's Stonature 31. Date filed (Month, Day, Year) State Registrar

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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and
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permit. Page Department of Important: If any injury or		21. Signature on transcral Service Licens	şe		22. Name and Addre KIRKLEY-R 421 CRAIN	UDDICK FU			•	
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur	edical Ce	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	tion and/	or investigation, in my o	pinion, death occu	rred at the time	, date and place, a	ner as stated. nd due to the cause(s)	i)
To th within To th	Me	29b. Signature and title of equitie	and manner stated. MD ompleted cause of death (Item 145 E. GJ 22. Registrar's Signa		29c. Licens	e number 63 980		29d. Date signed	(Month, Day, Year)	
10	ŀ	30. Name and address of person who co	ompleted cause of death (Item	23a) (Ty	(pe, Print)	hum n	17716	<i>\$\(\begin{align*}(1) \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\</i>		
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	Examir		4a. Facility Name (If not institution, give str	eet and number)			or Location of Death		4c. County	of Death	
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	Funeral Director		5. Social Security Number 217-64-5875 Usual Residence of Decedent	7. Age (In yrs. la	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08 0	rth ay, Year) 04 56	9. Birthp Coun	place (State or Foreign ntry) MD
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21215-0036	d within 72 hours after death with the Maryland glene. It than "natural", or items 23a or 28a-f show tr than "natural" or items 24a or 28a-f show the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏿 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2¶ No		o Rican, etc.)	Specii	ck, White, fy: B	lack
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68760,	certificate be executed ding physician and ise as the burial-transit	cal Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
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Records	2 28 2	Completed						24a. Was auto perfe		Were auto prior to cor death? 1 ☐ Yes	opsy findings available impletion of cause of
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_	nystc nis ce direc	ToE	1 ☐ Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3□ DOA Oth	ner: 4 Nursing Ho	ome 5 Resi	idence 6 □Otl	ner (Specif	·y)
0	ng Pt fter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	ry at rk?		how injury occur		
0	endil eath. or: A	atic	2 ☐ Accident investigation		. ,		Yes 2□No				
DIVISION OF	tal or Att rs after de ral Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or To		er or Rura	al Route Number,
	To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	ian: To the best of my know r: On the basis of examinati and manner stated.	rledge, death on and/or in	occurred at the ti vestigation, in my o	me, date and place, opinion, death occur	, and due to the rred at the time	cause(s) and m , date and place,	anner as st and due to	tated. the cause(s)
	To 1 with To t	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signe		
			Mosalyn	uergens w		D	60203		March	12	, 2008
	,4		30. Name and address of person who come	bleted cause of death (Item :	23a) (Type,	Print) 1 Johns 1	topkins C	RBT-G	193 Ba	ti mev	21231 P. Man law

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 - State Registrar	tate of Marylan		ertment of F ertificate of				2008	08534
r	73.1.		Decedent's Name (First, Middle, Last)			,	4	2. Date of Dea		Year	3. Time of Death
og A	Physici /Medic		Dorothy Mary Glase:	r				March			6:55 PM ^M
	Examir		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, o	r Location of Death	1	4c. Co	ounty of Death	
		8,	Manor Care Dulaney			Towson	T 16115 T 04 II			altimo:	
8. R	Funeral Director		213-03-2397	7. Age (In yrs. 95	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Jan 13	, Year) 1913	9. Birth Cou Mary	place (State or Foreign intry) 'Land
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Aaryla F sho ed at	ō	MD Baltimore		Tow	son					1 ☐ Yes 2√☐ No
	the 28a-	rect	10e. Street and Number	<u> </u>		10f. Zip Code			10g. Citize	n of What Cou	intry?
	3a or	Funeral Director	111 West Road			21	204			USA	
	ms 2	nera		Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H f Yes, specify Cuba		pecify Yes or No	. 14	. Race - Amer	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notitled at	þ	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Tes, specify Cobo	Specify:	o rican, etc.)		Black, White	, etc. hite
Ö	72 hor	Completed	15. Decedent's Educati (Specify only highest grade co	on ampleted)	16a. Deced	ient's Usual Occup	ation	kina	16b. Kind	of Business/I	ndustry
21	thin 7 le. an "r Med	를 E		College (1-4or 5+)	life. L	kind of work done OO NOT use retired	during most or wor	Nii ig			
7	ed wi ygien her th t, the	2	11	0		secretary					uel Synagog
pu	be fill ntal H id oth even	To Be	17. Father's Name (First, Middle, Last) Raymond Franklin Fo	vzb l o			18. Mother's Nan				0
λ	nould 1 Mer narke	မ			405 14-11	g Address (Street		ia Margu			
, Maryland	and 2 sl alth an 1 27 is r er traur		19a. Informant's Name/Relationship (Type. Jane Crabill/daught			Armacost					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☒ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Loca	tion - City or T	own, State
Balti	permit. Departn Importa any Inju		21. Sign fure of Funeral Service Licensee Remail S. Wa	de, Director	s St Ba	Name and Addre ate Anat ltimore,	omy Board	1 655 W.	Balt	imore	Street
			23a. Palt1. Enter the disease, or complicat shock, or heart failure. List only one of		h. Do not ent	er the mode of dyir	ng, such as cardiac				Approximate Interval Between
	Physician	ř h	Immediate Cause (Final disease or condition	Dur to (or as a conseq	a l	Vasci	Mar	Accid	lant	1	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	1	1				
	Examiner	.	Sequentially list conditions b	Atrial	Fi	brille	ation				
	po #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
	ecute and -trans	Examiner	that initiated events c c	Due to (or as a conseq	neuce of).						
60,	be ex cian burial	E		Due to (or as a conseq	dence oi).						
68760,	tificate be executed ig physician and as the burial-transit	edical	d								
×	eath certifi attending for use as	/Me	IF FEMALE: 23c.	If yes, outcome pf pregna	ancy				23	d. Date of deli	(OD)
Box	uires that the death cer signed by the attendin d be detached for use	Physician/M	in_the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	death 3	Ectopic pregnancy Other (specify)	/		251	Month	Day Year
P.O.	the d y the	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		, , ,, _,					
Ţ	s that ned b deta		Part II. Other significant conditions contrib	outing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
rds	quires n sig ald be	d by						1 🗆 `	/es 2	Ño 3□Pro	bably 4 □Unknown
00	aw requir s been si s should	lete						24a. Was			opsy findings available
æ	The lay te has age 2 :	Completed						autor perfo 1 Yes	rmed? 2 V No	prior to c death? 1 ∐ Yes	ompletion of cause of
ā	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea			1 🗆 163	212040
>	ding Physiclan: The After this certificate hi funeral director, page	To B	examiner? 1 ☐ Yes 2 DVNo Hos	pital: 1	ER/Outpatien	t 3□ DOA Oth	er: 4 Moursing H	ome 5 ☐ Resid	dence 6[⊒Other (Spec	ify)
0	ding Phys T. After this funeral di	ü	27. Manner of Death 1 Manual 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe l	now injury o	occurred	
<u>ō</u>	ath. or: Ai	atio	2 Accident investigation				Yes 2 ☐ No	_			
Division or Vital Records,	al or Attus s after de al Directus de in by ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif		eet, factory, office		28f. Location (8 City or Tox	Street and I vn, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certivithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1 Check only one) 1 Medical Examiner	an: To the best of my kno : On the basis of examina and manner stated.	wledge, deatl ation and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	- 20/1	An	29c. Licens	e number	U		signed (Month	
			· an /m		10		,5442			9-0	
			30. Name and address of person who comp	leted cause of death (Iten	n 23a) (Туре, Ис Л і С	em rdi	4209 7	imeniu	min	102	1.093
4	Sta Registr	_	31. Date filed (Month, Day, Year) NAR 1 7 2008	32. Registrar's Signa	ature	م					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	-548718 of Magazylan		rtificate of I		, ,	eg. No. 🧐 🎧	100	0057
2	Physici		Decedent's Name (First, Middle, Last) ANN A		GRE	EN		2. Date of Dea Month MALCH	Day	Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give FUTURE CA 5. Social Security Proper 6. See	RE OLD CO.	URT	4b. City, Town, or	Location of Death ACCS TOO If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County	of Death	1026 ace (State or Foreign
	0	_	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City	y, Town or Lo			121 21		10	Od. Inside City Limits
	h with the Mi 23a or 28a-fi st be notifie	I Director	10e. Street and Number 10236 Liberty Road			10f. Zip Code 21133		1	0g. Citizen of USA	What Coun	1 ∐ Yes 2 💆 No try?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		by Funeral	11. Marital Status 1 □ Never Married ② Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 27 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ce - America ck, White, (少 whit e	etc.
		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation		dent's Usual Occup kind of work done o DO NOT use retired eria work		ing	16b. Kind of B	d ser	ŕ
uld be filed v fental Hygie rked other	To Be Co	17. Father's Name (First, Middle, Last) Wilhelm Bischoff		1 34200	la war	18. Mother's Nam	e (First, Middle, ne Amhre	Maiden Surnai		1100	
Wal y	alth and M 27 Is mar	-	19a. Informant's Name/Relationship (Ty Eugene Green (spou	•		ng Address (Street) Liberty					Code)
Dalilli Jore,	rages I are ment of He tant: If item jury or othe		20a. Method of Disposition	emoval from State	emetery, crer rison	sition (Name of matory or other place Forest Ve	et. 3-19	- 08	20c. Location)wings	Mills	, MD
ב ב	Depart Depart Import any in		21. Signature of Funeral Service Licens Pauge Haight 3			2. Name and Addres				me & (Chape1
	hysician and /Medical sa the prival-transit	edical Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Irijury that initiated events resulting in death) Last		uence of):	TIA					Approximate Interval Between Onset and Death
The law sequines that the death and ifine	w requires that the death certifical been signed by the attending phy should be detached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
1 60 000	quires triat in signed by uld be deta	by P	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.				e cause of death? ably 4 Punknown
	ite has	Completed						24a. Was a autop: perfor 1 Yes	med?	prior to cor death?	osy findings available npletion of cause of
hundialan T	nis certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 6	lospital: 1 🗌 Inpatient 2 🗍	ER/Outpatien	ot 3 DOA	26. Place of Deat er: 4 Nursing Ho	h <i>(Check only or</i> ome 5 ☐ Resid		her (Specify	·)
Attending by	To the Toppina of Attenting Frigorians within 24 hours after death. To the Funeral Director. After this certification ompletely filled in by the funeral director, p.	Certification:	27. Manner Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	yat k? Yes 2 □ No	28d. Describe h	ow injury occu	rred	
A de letie	urs after d		4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	y)			28f. Location (S City or Tow	n, State)		
tho Hoe	the Fundant	Medical	(Check only 2 Medical Exami	sician: To the best of my kno- ner: On the basis of examina and manner stated.	wiedge, deati tion and/or in	vestigation, in my o	pinion, death occu	red at the time, o	late and place	, and due to	the cause(s)
F	Z William	2	29b. Signature and title of certifier	()	4.0	29c. Licens			9d. Date signe		
	4		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	1120		MAC	n 14	2008 LEMPZILL
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	1838	GREENE	TREE	KUAP H	500 (°110	CESVICE	E M p ZILL

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Registrar

State

29b. Signature and title of certifier

32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

NICHELSUN, MD 750 Main St Reliteration, MD 21136

29c. License number

0606 80

29d. Date signed (Month, Day, Year)

08-01966			ease Ty	oe or Print i	n Black In	delible ink	. Ensur	e All Copi	es Are Lo	egible		
Malik Michael Ha		1- For State	St	ate of Maryla		rtment of H tificate of D		id ivientai F	iygiene		200	0853
Physicia		Registrar 1. Decedent's Nam	e (First, Midd	le.Last)	<u> </u>	inicate of D	Cati		2. Date of De			3. Time of Death
Medical Exami		Malik			ichael		Ha	san	Month March 1	0, 2008	Year }	0531 hrs
-		4a. Facility Name (on, give street and nu	ımber)		City, Town, or	Location of Deat	h		County of Deat	
		24 Stockmi	II Road Ap				Pikesville	- I () O ()	le Date of		Baltimore Co	irthplace (State or
Funeral		5. Social Security I	Unk	6. Sex	7. Age (In yrs. la		f Under 1 Year Months Day		n.		Forei	ign
Director		_		X X M 2 F		Yrs. (06 0	9	08	31	07 ^c	ountry) MD
any		Usual Residence of 10a. State	10b. County		10c. City,	Town or Location						10d. Inside City Limits
	_	MD	Balt	imore		Pikes	ville					1 Yes 2 XNo
faryla 28a-f	Director	10e. Street and Nu	ımber			1	0f. Zip Code			10g. Citi	izen of What Co	untry?
eath with the Maryland items 23a or 28a-f show ust be notified at once.		24 Scot	tmill	Road A				208			U.S.A	
th with	Funeral	11. Marital Status 1 Never Marri	ied 2 N	12. Was De Armed F				ispanic Origin? (: in, Mexican, Puer		No-	14. Race - Ame White, etc.	erican Indian, Black,
er deat , or it	Fur	3 Widowed		1 Yes	2 X No	1 V	es 2 X N	o specify:			Specify:	Black
ırs aft tural"	d by			or Dates: ecify only highest gra		16a. Decedent's	Usual Occupa	ation (Give kind o		16b.	Kind of Business	s/Industry
72 hou "na	Completed	Elementary/Sec	condary (0-12)	College (1-4 or 5+)	during most	of working lif	e. DO NOT use re	etired)			
1036 Athin ene.	mp	N/A		N/A		N,	/A				N/A	
15-0 filed v Hygi d oth		17. Father's Name	•	-				18.Mother's Nar			i Surname)	
212. Ild be Mental narke	o Be	Michael				19b. Mailing A	ddress (Stre	Shyana eet and Number o	r Rural Route	Number, C	City or Town, Sta	te, Zip Code)
AD 2 2 shou 1 and 1 27 is r matic	_			Grandmot	her	4706	Garri	son Blv	d, Ba	ltim	nore, M	ld 21215
e, North		20a. Method of Dis	sposition		20b.	Place of Disposition		emetery,	Date	20c.	Location - City of	or Town, State
MOr Pages ent of nt: If		1 X Burial 2			rom State Kii	•	orial	Park 3	3/15/0	8 Ra	andalls	stown, Md
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign ture of F	uneral Servic	e Lic + see	1	22. Nan	ne and Addre	ss of Facility H West				
		-W	mi	r complications that	erc	430	Wab	ash Ave	. Bal	time	ock or head	21215 Approximate Interval
Physician /Medical		23a. Fart I. Enter t ailure. List o	ne disease, d by one caus	e on each line.				g, such as cardiac	, or respiratory	arrest, si	lock, of fical case	Between Onset and Death
kaminer		Immediate Cause or condition result			alation and t	thermal injurie	S					
		Sequentially list c		b								
	ner	if any, leading to i cause. Enter Und	mmediate		a consequence of	of):						
V -	cam	(Disease or injury events resulting in	that initiated	Dua 40 /07 00	a consequence of	of):						
cecured 1 and - transit	cal Examiner			d								
), be exe sician	dic	UNPENDE	D	AMENDED						- 12		
68760, certificate be nding physici	an/Medi	IF FEMALE: 23b. Was deceden			, outcome of preg birth		death 3	Ectopic preg	nancy	2	3d. Date of delive Month	ery Day Year
Box 68760, e death certificate be exthe attending physician ed for use as the burial	sicia	past 12 month		4 Preg	nant at time of d	anth =	r (Specify)			- 1		
Box ne death co	Phys				nown	resulting in the unc	dorlying saus	n given in Part I	23e D	id tobacc	o use contribute	to the cause of death?
i, P.O. ires that the signed by	by F	Part II. Other sign	nificant cond	itions contributing	to death but not	resulting in the unc	zerrynng cause	e giveirii raiti.			✓ No 3 P	
rds, Frequires been sig	ted								24a. V	/as an		autopsy findings available
cords law requi has been	Completed	L							- _p	utopsy erformed	? death	
tal Rection: The certificate ector, page	Sol						26 DIa	ice of Death (Che		es 2 🗸	No 1	Yes 2 No
ital F sician: is certifi irector,	Be	25. Was case refe examiner?		Hospital:	Inpatient 2	ER/Outpatient		Tou	rsing Home 5	Resid	dence 6 🗸 Ot	her: Scene
Division of Vital Records, tal or Attending Physician: The law requirnrs after death. "In Director: After this certificate has been silled in by the funeral director, page 2 should t	<u>유</u>	1 ✓ Yes 27. Manner of De	2 No ath	28a. Dat	e of Injury th, Day, Year) 2008	28b. Time of Inju	ury 28c. Ir	njury at Work?			njury occurred	
On cending ath.	tion	1 Natural		iunig	2008, rear)	0115 hrs	1_	Yes 2 V No	apartme	it iire		
ViSi or Att fter de Directe in by 1	ifica	2 Accident 3 Suicide		estigation 28e. Pla	ace of Injury - At I	nome, farm, street,	factory, office	e building, etc.	28f. Location	on (Street	t and Number or	Rural Route Number, City
Dispital of ours at filled	Certification:	4 Homicide			/) Multi-Fam						Apt. J, Pikesv	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and neletely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier (Check only one)	Certifying	Physician: To the bearing: On the basis	est of my knowle	dge, death occurre and/or investigatio	d at the time,	date and place, a ion, death occurre	and due to the ed at the time, o	cause(s) a date and p	and manner as s place, and due to	stated. o the cause(s)
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature an		and manner	stated			nse number				Month, Day, Year)
	[Jan. Digitature all	, /	//ext	T dip		- 1	C.M.E.		М	arch 11, 200	8
		30. Name and add	dress of person	on who completed ca		m 23a)			*			
,7		Tasha Gre			Medical Exar		enn Stree	t, Baltimore,	MD 21201			
S	tate	31. Date filed (Mo	nth, Day, Yea	r) 32.	Registrar's Signa	ture	AP 0					

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Registrar

OCME

ORIGINAL

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Ma	arylar	nd / Depa		of H	ealth a		lental Hyg			08539
- 6	Physic	ian	Decedent's Name (First, Middle,	Last)							Date of Death Month	Day	Year	3. Time of Death
	/Medi	cal	Gloria Mae 4a. Facility Name (If not institution,								MARCH	15	8008	6.15 AM
	Exami	ner	Baltimore Wa	,	Mod	C+m	4b. City, T						ty of Death	1 7
	Funeral					last birthday)			urni		8. Date of Birth			undel
L	Director		212-28-6399 Usual Residence of Decedent	1□M 2 ⊠ F	8	O Yrs.	Months	Days	Hours	Min.	(Month, Day, 02/22/	^{Year)} 1928	Cou	place (State or Foreign ntry) MD
	arylar show dat	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Ba-f	Scto		Arundel	P	'asade	na							1 □Yes 2XNo
	with t	Funeral Director	10e. Street and Number	D 1			10f. Zip (_		10	g. Citizen o		ntry?
	eath	era	188 Carroll 11. Marital Status	KOAO 12. Was Decedent E	Supr in II	6 1101		122		1.0.0		U.S.		
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	Armed Forces?			rvas Decede If Yes, specif 1 ☐ Yes 2			gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)			etc.
9-0	72 ho	ted	15. Decedent's	Education	-	16a. Deced	ient's Usual	Occupa	tion		1	6b. Kind of I		uite _{dustry}
21	ithin 7 ne. nan "r ned	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give life. L	kind of work OO NOT use	done di retired)	uring most	of worki	ng			,
21	lygier ygier ner th	S	12			Но	memak	er				Own	Home	<u>!</u>
and	htal H	Be	17. Father's Name (First, Middle, La	,							(First, Middle, M		me)	
Z Z	d Me mark	유	Frank L. (T					a Shan			
Sa	th an		Ernest Hube								l Route Number,			Code)
<u>a</u>	s 1 ar f Hea ftem 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	of	i		sadena,	MD 2 Dc. Location		Divin State
e E	Pages ent of ht: If I		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		0	emetery, cren	natory or oth	er place		_			•	
alti	permit. Pag Department Important: I any injury c		21. Signature of Soneral Service Lie		меа	adowri	. Name and	Iem_ Address	PK U	$\frac{3/1}{C}$	9/08 E	alti	more.	MD Home, PA
ä	Imp any any		My Jan			1	69 R	izzi	ora	Driv	J.GONCE	run	eraı . Mi	ноте, РА Э 21122
2			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused	the death	n. Do not ente	er the mode	of dying	, such as o	cardiac o	r respiratory arres	t,	a, FII	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			nong								Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequ	uence of):								
	Examiner	_	Sequentially list conditions,	b. URO										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	uence of):								
PK	xecut and al-tran	хап	that initiated events resulting in death) Last	c Due to (or as a	CORRORI	lence of):								
8760,	ate be executed nysician and he burial-transit	ical E			consequ	ichice ory.								
68	certificate be executed ding physician and see as the bunal-transi			d										
B.	death e atter d for u	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal	death 3 🗆	Ectopic preg Other (spec						ate of delive	ry Day Year
	s that ned b e deta	by Pt	Part II. Other significant conditions	contributing to death but	not resu	iting in the un	derlying caus	se given	in Part I.		23e. Did toba	cco use con	tribute to th	e cause of death?
Division or Vital Records,	requires that the sen signed by the ould be detache	ed b									1 ☐ Yes	,		ably 4 ⊡Unknown
ည်	has ber	Completed									24a. Was an	24b.	Were autor	osy findings available
Ä	The ate high	E O									autopsy	d?	prior to con death?	npletion of cause of
/ita	ilcian: Th certificate ector, pag		25. Was case referred to medical examiner?					2	26. Place o	of Death	1□ Yes 2 (Check only one)	ZINO	1 □ Yes	2 No
7	hysle this ca all dire	ဥ	1 Yes 254 No	Hospital: 1 Inpatien	2 🗀 E	R/Outpatient	3□ DOA	Other:			e 5 Residen	e 6 🗆 Oth	ner (Specify	·)
u .	ding Physician: The n. After this certificate ha funeral director, page		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		28b. Time of Injury	28c	Injury a	at		3d. Describe how			,
Sic	ttend death stor: ,	cati	2 Accident investigati 3 Suicide 6 Could not	he			М		s 2∐N	0				
)i	or A after Direction by	Certification:	4 ☐ Homicide determine	28e. Place of injur building, etc.	/ - At nor (Specify)	ne, tarm, stre	et, factory, o	ffice		28	Bf. Location (Stree City or Town,	et and Numb State)	er or Rural	Route Number,
	spital ours neral filled		29a. Certifier 15 Certifying F	Physician: To the best of	mv knov	vledne death	occurred at	the time	data and	place a	- d du - à - àl			
	To the hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical	(Check only 2 Medical Ex-	aminer: On the basis of e	xamımatı	ion and/or inv	estigation, in	my opir	, date and nion, death	piace, ai	d at the time, date	se(s) and m e and place,	anner as sta and due to	ated. the cause(s)
	To the comp	Me	29b. Signature and title of certifier				29c. L	icense n	number		29d	Date signe	d (Month, E	Day, Year)
			12/601	me mo			0	000	5919	0	IV.	ARCH	i 7	2008
-	8		Name and address of person wh	oompleted equips of dea	th (Item	23a) (Type, P	-!-+\							
0.10	V		FLORCE GATT 31. Date filed (Month, Day, Year)	10000000	. Clar-	sc1 H	TIGZE	1	DRY	J € .	ELEN	1301	NUE, M	no 21061
	Stat Registra	~	Fig. Date filed (Month, Day, Year) MAR 1 7 200	32. Hegistrar	Signati	Sports								

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MYORIA HURGI

08-02059	Please Type or Print in Black Indelible Ink. Ensure All Copies	Are Legible.
Jamal Alphonso Hari	State of Maryland / Department of Health and Mental Hygi	2002 0251.0
	1- For State Certificate of Death	Reg. No. Date of Death 3. Time of Death
Physician/	1. Decedent's Name (First, Middle Last)	Month Day Year 1812 hrs
Medical Examiner	Children Troppingo Troppingo	4c. County of Death
	4a. Facility Name (if not institution, give street and number) 1915 Rosedale Street 4b. City, Town, or Location of Death Baltimore	
,	Millinder 1 Vogs If Linder 24Hrs 8	. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	Months Days Hours Min.	05 11 1985 Foreign Country) mD
Director	X16 0: 3780 X = 1	
è	Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location	10d. Inside City Limits
, a d	MD Baltimore Kandallstown	1 Yes 2 No
n-f sh	10e. Street and Nymber 10f. Zip Code	10g. Citizen of What Country?
r death with the Maryland or items 23a or 28a-f show any must be notified at once. Funeral Director	9955 Shashone Way 21133	USH
ath with the items 23a ast be notional ineral in	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Dright? (Speci	fy Yes or No- 14. Race - American Indian, Black, white, etc.
death wi	1 Never Married 2 Married Armed Forces?	Dlook
merdalli, or	3 Widowed 4 Divorced of Dates:	Specify: DIWK
ours aft	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired during most of working life. DO NOT use retired	
6 172 h an "n cal E	Elementary/Secondary (0-12) College (1-4 or 5+)	Votail
5-0036 led within 72 hour Hygiene. other than "natu the Medical Exan Completed	10th Lashier	irst, Middle, Maiden Surname)
Hygin Hygin doth	17. Fainer's Name (First, Michiel Last)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rw	al Route Number, City or Town, State, Zip Code)
MD 21 d 2 should the and Mel m 27 is ma aumatic ev	Tracey Toney (Mother) 19955 Shoshone Wa	
and 2 lealth tem 2 traun	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
ore ges 1 t of H si If i	Sunal 2 Community of the sunal	0.08 Baltimore, MD
Baltimore, permit. Pages I ar Department of Her Important: If ite	4 Donation 5 Other Specify: 21. Signet e of Funer Service Licensee	e Funeral Services
Balti permit. Departm Importa injury o	Variation (National Sister Nat)	rile (2/2/1)
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r	espiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds	Death
xaminer	or condition resulting in death) Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ine	if any, leading to immediate eauce. Enter Underlying Course c. C.	
ted of the saminer	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
on ±		
	UNPENDED AMENDED	23d. Date of delivery
). Box 68760, the death certificate be to yot the attending physicia ched for use as the burial Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnan	cy Month Day Year
x 68 h certi tendin use a	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
BO) le deatl the att	1 Yes 2 No 9 Unknown 9 Unknown	23e. Did tobacco use contribute to the cause of death?
b, P.O. ires that the signed by a be detach		1 Yes 2 No 3 Probably 4 Unknown
ires th		24a. Was an 24b. Were autopsy findings available
Records, The law require. ficate has been sign, page 2 should be		autopsy prior to completion of cause of death?
ecc he lav		1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical	
Division of Vital Records, rain and retain The law require and the dear the law requirements and piece and the first field in by the funeral director, page 2 should be extended to the formula of the formula	1 ✓ Yes 2 No	o Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred
n of hing Ph	27 Manner of Death Zoa, Date of Illium 200, Title of Illium	Subject shot
ion tendi for: /	1 Natural 5 Pending Natural 5 Pending Nat 13, 2008 1810 hrs 1 Yes 2 No No Nat 13, 2008 1810 hrs	28f. Location (Street and Number or Rural Route Number, City
VIS or At filter d Direct in by	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, State) 1915 Rosedale Street, Baltimore, MD
E 3 5 E (determined (Specify) Beside Local Street	
To the Hos within 24 h		t the time, date and place, and due to the cause(s)
To the He within 24 To the Fu completel	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	29b. Signature and title of Certifier O.C.M.E.	March 14, 2008
4		
OCME	30. Name and add so of person who completed cause of death (Item 23a) Mary G. Ropple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M	D 21201
	W.D. 1 - 2000 Facilitate Simplifies	
Star Registra	(e	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per me 9878.04/01/08dhb

Amend Item 11 per fh, 2877.03/21/08dhb

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** Donnell Henry Rickey 200 g 1150 A II /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7426 KAL TON Pikesville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Mary Land 1 M 2 ☐ F Months 26 Director 220-96-7161 May 27, 1981 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f ehow 10d, Inside City Limits treumatic event, the Medical Examiner must be notified at Pikesville, Director MI) Baltimore 1 ☐ Yes 2 X No 10e, Street and Number 10g. Citizen of What Country? ō 7426 KALTON Ct. U.S.A. Items 23a Funeral 21208 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or ite Never Married 2 Marned 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Rickey Henry Manning 2 Sri Dora Ti 19a. Informant's Name/R lationship (Type, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health at Importent: If item 27 is any injury or other tree. RICKEY Henry 7426 KALTON Ct. PIKESVILLE MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lorraine Cemetery Mar 14,2008 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Remarks of Facility
Remarks to Concursion Funeral Service
270 Fred, Leton Pass, Bully mg 21229 trayen mald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such; as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4sphy X/a Hanging り /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed ام هام Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed been (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificete 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 XYes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending İnjury Suicide by Hangino 2 Accident investigation March 9,2008 unknown 1 ☐ Yes 2 XNo 3 Suicide 4 ☐ Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 7472 Nathan E. Prkes wille, Md 21208 Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ş 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 018667 Deput March Philip Militello, MD 6 Trimble Will CT. Lutherville, MD 21093

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 7 2008

32. Registrar's Signature

1000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland .	-	artment tificate					giene Reg. No.	000	00542	
	Physici	ian	Decedent's Name (First, Middle, Las								2. Date of Dea	Day	Year	3. Time of Death	
	/Medi	cal	Annabelle B. Hen 4a. Facility Name (If not institution, give		3		4h Cih, T		Location of		March		008 County of Deat	3:30 PM M	
	Examir	ner	2809 Leafshade I		,				t Cit		Howard				
	Funeral		5. Social Security Number 6. Se	7. A	ge (In yrs. last	birthday)	If Under		If Under	24 Hrs.	8. Date of Birt	th v Year)	9. Birtl	hplace (State or Foreign untry)	
	Director		5//-94-1955	⊒M 21∏F	94	Yrs.	WORKINS	Days	Hours	IVII().	(Month, Da Mar 21	, 19	13 Wash	ington DC	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits	
	Mary	ō	MD Howard		E-1	1100	tt Ci	- 37						1 ☐ Yes 2 ☐ No	
	h the	irec	10e. Street and Number		1 11	LICO	10f. Zip					10g. Citiz	zen of What Co	untry?	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int. Its Medical Exactinat rout the notified at	Funeral Director	2809 LEafshade Di	ive				2	1042				USA		
	tems tems	nuel	11. Marital Status	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								 Race - Ame Black, White 			
36	rs att	by F	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	Never Married 2 ☐ Married 1 ☐ Yes 2 ₹ No 1 ☐ Yes 2 ₹ No 1 ☐ Yes 2 ₹ No Specific Till Yes 2 ₹ No								ite			
5-0036	2 hou	ted	15. Decedent's Ed	ucation	1	6a. Deced	lent's Usual	Occupa	ition			16b. Kir	nd of Business/	Industry	
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	(Give life. L	kind of work DO NOT use	k done di e retired)	uring mosi	t of workin	9				
2121	ygien ygien her th	Son	12	0		ho	usewi						own hom	e	
	ould be filed with Mental Hygiene arked other than atic event, It at	Be	17. Father's Name (First, Middle, Last)	_					18. Mothe		(First, Middle,		Sumame)		
2	should ind Men ind Men in marke	2	Henry F. Haard 19a. Informant's Name/Relationship (7)			19h Mailir	a Addrass	/Street a	nd Numbe		McCar		Town, State, 2	Zin Code)	
Ma	~ ~ ~ ~		Joseph Hensley/s				-				llicot			21042	
Je,	to ther tr		20a. Method of Disposition		com	e of Dispo	sition (Nam natory or oti	e of her place	e)	Da	ite	20c. Loc	cation - City or	Town, State	
<u><u>ä</u></u>	Pages nent of the ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify			,,	,		,						
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any Injury or othe		21. Sign fure of Expera Scient to the Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										Street		
			23a. Part1. Enter the disease, or composhook, or heart failure. List only of	ications that cause one cause on each I	d the death. [respiratory ar	rrest,		Approximate Interval Between	
y	Physician		Immediate Sause (Final disease or condition resulting in death)	aCc	andli	00	me	na	2	Ay	nes!	_		Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of)		1		. 1-		4	3. 2		
	*	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	b. Due to (or as	a consequen	ce of):	· W	th	151	ght	PCIV	CMT	< 15	-	
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Java	movs	Ce	-11	-CN	un	(tuon	(1			
0,	e be executed /sicien and e burial-transit		resulting in death) Last	Due to (or as	a consequen	ce of):						-			
8760,	icate b physic s the bi	dica	•	d	1-4-At	m-	ens	12	<u> </u>						
Box 6	The law requires thet the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached tor use as the burial-transit	Physician/Medical	230. Was decedent pregnant	23c. If yes, outcome			Ectopic pre	onancy	·			2	23d. Date of del	- /	
P.O. E	at the dea by the at tached to	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant a 9⊡ Unknown	it time of death		Other (spe						Month	Day Year	
<u>a</u>	s thet the need by a detact	by Ph	Part II. Other significant conditions co	ntributing to death t	but not resultin	ng in the ur	nderlying ca	use give	n in Part I.		23e. Did to	obacco us	se contribute to	the cause of death?	
Vital Records,	w requires been sign should be	ed	ho Pace	-malie	· N	ale	mer	+			101	Yes a	5(No 3□ Pr	obably 4 \(\sum \) Unknown	
ဝင္ပ	law re as be 2 sho	Completed									24a. Was		24b. Were au	Itopsy findings available completion of cause of	
æ	The The Sate has page	S S									perfo	rmed? 2 No	death?	~	
/ita	siclan: Th certiticate rector, pag	Be	25. Was case referred to medical examiner?	11				I.o.		of Death	Check only o	one)			
of	Phys this aldii	2	1 ☐ Yes 2 ② No 27. Manner of Death	Hospital:		Outpatien b. Time of			4 140		e X Resid		Other (Spec	cify)	
	ding Atter	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ay Year)	Injury	M	lc. Injury Work	? ′es 2 🔲 i		od. Describe	now injury	occurred		
Division	Attending or death. ector: After by the funer	Certification;	3 Suicide 6 Could not be	28e. Place of In	jury - At home	, farm, str				-	8f. Location (5 City or Tox			ural Route Number,	
ā	9 # 2 ™			4	tc. (Specify)										
	Hospital 24 hours a Funeral I stely tilled	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam one)	rsician: To the best iner: On the basis of and manner st	of examination	dge, death and/or inv	occurred a estigation,	it the timi in my op	e, date an inion, dea	id place, ai th occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and mainer s	ialou.		29c.	License	number	(^)		29d. Date	e signed (Monta	h, Day, Year)	
	->= 0		D LLA				1	23	917	78		Mai	uch 11	,2008	
			30. Name and address of person who o	ompleted cause of	death (Item 23	la) (Type,	Print)		~·						
			James Ono M	S 883	5 Cul	4		00	NAY	1,5	uiter	7 / 1	plumpia	MD 2104	
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 1 7 20	32/Regist	rar's Signature	A DE	and a								

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6756 Ridge Road Marriottsville, MD 21104 20c. Location - City or Town, State Sykesville, MD HATCHT FUNERAL HOME & CHAPEL, P.A. 100764 PO Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death Year > 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title_of certifie 29d. Date signed (Month, Day, Year) 100051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manchest 1). Hiero Wn 2973 Manche Herbert lerson Sc 32. Registrar's Signature 31. Date filed (Month, Day, Year) **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

12:00pm

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 XNo

2008^{ar}

Carrol1

Black, White, etc.

State Registrar

17

within 24 hours a

To the Funeral I

completely filled filled

Hospital

DHMH 17 Rev 1/2001

8-02010

2008 08544 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Nathena Harris Certificate of Death Reg. No. 1- For State Time of Death 2. Date of Death Registrar Month Day March 11, 2008 Deçedent's Name (First, Middle,Last) 2250 hrs ysician/ xaminer Med 4c. County of Dear 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 910 St. Paul Street Apt. A 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Hours **Funeral** Days Country) Months Yrs Director 1 M 2 X F 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 1 X Yes 2 No 10b. County 109. Citizen of What Country? of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho ther traumatic event, the <u>Medical Examiner must be notified at once.</u> Director 10e. Street and Number Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. White, etc. Funeral 11. Marital Status Armed Forces? 1 X Never Married 2 Married Yes Yes 2 No specify: If Yes, Give Yeer 4 Divorced 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ۵ 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) (Step Father) 2 Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 12008 Baltimore, Removal from State 1 Burial 2 K Cremation 3 permit. Page Department o Important: injury or oth Donation 5 Other Specify: 22. Name and Address of Facility Joseph L. Russ 21. Signature of Funerah Service License Approximate Interval ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Jailure. Listonly one cause on each line. Mixed drug(methadone, propoxyphene and hydrocodone) and ediate Cause (Final disease a. alcohol intoxication complicated by pneumonia Death sician , Medical Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last AMENDED 23a, 27, 28a-f per ME g877 3/25/08 amh and sician/Medical X UNPENDED physician the burial -23d. Date of delivery To the Hospital or Attending Physician: The law requires that the death certificate be-23c. If yes, outcome of pregnancy Year Box 68760 IF FEMALE: 3 Ectopic pregnancy Month Fetal death 23b. Was decedent pregnant in the Live birth attending | for use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for Unknown 23e. Did tobacco use contribute to the cause of death? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Phy 1 Yes 2 No 3 Probably 4 V Unknown o ğ نے 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of Records, certificate has been sector, page 2 should autopsy death? performed? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Nursing Home 5 Residence 6 ✔ Other: Scene Other: Be Division of Vital Hospital: DOA ER/Outpatient 3 Inpatient 2 this 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Dey, Year) 27. Manner of Death After 1 Yes 2 X No Certification: Natural Found 10:30pm Inknown 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 910 St Paul St. Apt. A found 3/11/08filled in by the f within 24 hours after death. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident 6 X Could not be 3 Suicide determined (Specify) Found at home To the Funeral completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Homicide 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 1 Medical 29d. Date signed (Month, Day, Year) and manner stated 29c. License number 29b. Signature and title of certifier March 12, 2008 O.C.M.E.

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person

Jack Titus MD.

2008 MAR

Deputy Chief Medical Examiner 32 Registrar's Signature

who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

OCME

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

KAZMI, Mr

3. Registrar's Signature

A

31. Date filed (Month, Day, Year)

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AVE MUEDERIAL MD 2170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 13 1655 Wilbur H. King 2000 LAREN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/01/1922 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 ☐ F 85 Director 234-22-5664 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 TNo Director Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 818 Seckel Court 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event the next Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Forestry Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph King Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 Seckel Court, Baltimore, Grant King (Son) Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State Dulaney Valley Memorial 03/18/2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ignatu of Funeral Service Lic in ee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 days SEPTIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIFFICILE COLITIS LOSERIDIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the death certificate be executed and Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by should be detac The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? Yes 2 No 2 No Vita or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division or this 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1374

KING,

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUEGORBULEV

2008

ORIGINAL

2008

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900 S. CATON AVE

BALTIMORE, MA 21229

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32. Registrar's Signature

SAP

08-02	075
Willie	Kitrell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villie Kitrell			State of Maryland / Department of 1- For State Certificate of Registrar		Reg. No.	2008 0854
Phys Medical Exa			1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day	3. Time of Death Year 1341 hrs
Neulcai Exa	amm		Willie Kittrell, Jr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	March 14, 2008	. County of Death
			Mercy Hospital	Baltimore		N/A
Fune	ral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		s. 8. Date of Birth(MM/	DD/YYYY) 9. Birthplace (State or
Direct			220-86-9523 12 M 2 F 46 Yrs	Months Days Hours Mir	June 23,	Foreign 1961Country) Marylar
			Usual Residence of Decedent			I do a la cida Oik i limita
W 20 V	≛	- 1	10a. State 10b. County 10c. City, Town or Locat Maryland N/A Baltimor			10d. Inside City Limits
Maryland 28a-f show	once	ģ	10e. Street and Number	10f. Zip Code	I 10g Citis	zen of What Country?
e Mar	notified at once	ଥା	3315 Elbert Street		log. Gita	
vith th	noti	اڃ		21229 as Decedent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - American Indian, Black,
eath v	ust b	Funeral		es, specify Cuban, Mexican, Puerto		White, etc.
after d	ner m	by Fi		Yes 2 X No specify:		Specify: Black
nours	xami		during m	it's Usual Occupation (Give kind of ost of working life. DO NOT use ref	irod)	Kind of Business/Industry
36 n 72 h	ical	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	city Officer	St.	. Agnes Hospital
with grene.	Ne	Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Malden	Sumame)
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	nt, th	Be	Willie Kittrell. Sr.	Mamie I	ee Gibsor	1
21; ould b	ic eve	.0	19a. Informant's Name/Relationship (Type, Print)	g Address (Street and Number or	Rural Route Number, C	ity or Town, State, Zip Code)
MD od 2 sho	uma uma		Maicolm Max Kittrell/Brother 500	NW 141St AVE	enue Pembr	rooke, Florida
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If then 27 is	or other traumatic event, the Medical Exa	-1	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State crematory or ot	sition (Name of cemetery, her place)	22/08 20c.	Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee	or of		4 Donation 5 Other Specify: Western	Star Cemetery	, Çat	onsville,Marylar
Salt ermit.	in jud		21. Signature of Funeral Service Licensee 22. N	Name and Address of Facility	natman-Har	ris Funeral Home
		4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter t			Ltimore, Md 21215
Physici /Medi		-	failure. List only one cause on each line.		o, 100p., a.t., y a.t. 60., a.t.	Between Onset and Death
xamir	ner	- 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	DOIISM		
			Sequentially list conditions, b. Right Leg Deep Vein Thrombosis			
		miner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
/	Ţ	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed	burial - transi		d			
60, ebe execut	urial -	ledical	UNPENDED			
	g pnys	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	etal death 3 Ectopic pregn		d. Date of delivery Month Day Year
Box 6876 death certificate	for use as the b	sician/M	past 12 months? 4 Pregnant at time of death 5	ther (Specify)	laticy	World Day Toll
Bo) e deatl	ed for	Physi	1 Yes 2 No 9 Unknown 9 Unknown			
P.O.	ゔ┇	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
S, F	Id be deta	ed k	Atherosclerotic Cardiovascular Disease			No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requing and a fairer dealh.	2 shou	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Rec The la	page	ĕ			1 ✓ Yes 2 N	
tal Rec cian: The	funeral director, page	Be	25. Was case referred to medical examiner? Hospital: A lengtion 2 M ER/Outcation	26.Place of Death (Check		- [] - :
f Vi Physi	ral dir	೭	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		ing Home 5 Reside	ence 6 Other:
n of In of		ë	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	200. Describe now my	ary occurred
isio Atter	by th	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, stre		28f. Location (Street a	and Number or Rural Route Number, City
talor Is after	led in	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, State)	
Division Hospital or Attend 24 hours after death Fineral Directors	ely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	rred at the time, date and place, an	d due to the cause(s) ar	nd manner as stated.
Division To the Hospital or Attent within 24 hours after death	completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.	tion, in my opinion, death occurred	at the time, date and pla	ace, and due to the cause(s)
¥ ½ ¥	- 8	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			My W, MD	O.C.M.E.	Mai	rch 15, 2008
		ŀ	30. Name and address of person who completed cause of death (Item 23a)			
	0		Ling Li, MD Assistant Medical Examiner 111 Penn Stree			P
		ate rar	31. Date filed (Month, Day, Year) 2008 32 Registrar's Signature	w		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear Knickman Elizabeth 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea osedale Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 □ M 2 X F 217-12-9276 1922 85 Aug. B, Marviand Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits Baltimore Middle River 1 TYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 **USA** 7117 Cunning Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Albert Raymond Christopher Lavery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nursery Lane, 17404 Patty Moore (Daughter) York. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State Garrison Forest 03/18/2008 Reisterstown, Maryland 4 Donation 5 Dother (Specify, nature of FA 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 5. Coster 21204 1050 York Road, Towson, Maryland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LMonaru Due to (or as a cons, quence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ve Pulmonary Embolism IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 □Unknown . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed ્રે Division or Vital Records, P.O. Box 68760, physician by certificate I the Hospital or Attending Physician: this After t Director: / inc.
In 24 hours a.

o the Funeral Direct

Examiner Physician/Medical à Completed Be P Certification: Medical

Physician

/Medical

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Director

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Director

ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If item 27 is marked other the any Injury or other tweether the

Physician /Medical

Examiner

Registrar

29a. Certifier

(Check only

29b. Signature and Atle of certifier

31. Date filed (Month, Day,

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year. MAR 17

9000 Frank 32 Registrar's Signature

29c. License number

† Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year 2008 W15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Home SING 5. Social Security Number Age (In Date of Birth (Month, Day, Birthplace (State or Foreign Country) Hours Min. Months Days 1 □ M 2 F 220-20-3905 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 XYes 2 No MARULAND 10e. Street and Number 10f. Zip Code 10g. Citize of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No 3 Widowed 4 Divorced ACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, WATKINS WILLIAM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License TK, FUNERAL HOME ua ULTON AVE. BALTO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Soure disease or condition resulting in death) nsequence of): perten Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Norsing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Inpatient 28a. Date of Injury 28h Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner The law requires that the death certificate be executed physician and the burial-trans Box 68760. attending physician for use as the buria signed by the a d be detached fo P.O. Division or Vital Records, been si should I cate has page 2 s this certificate or Attending Physician: director, After thi funeral within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Examiner Physician/Medical þ Completed Be Medical Certification: To

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be and Mental

with the Maryland

27. Manner of Death 1 Natural 2 ☐ Accident 3 ☐ Suicide

29a. Certifier (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No

4 Homicide determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Lacritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

Mn

29c. License number D31464 29d. Date signed (Month, Day, Year) 00

A 31. Date filed (Month, Day, Year)

tastam mD 821 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. ENTAW ST Sinte 308, BALTIMORE MD

State Registrar

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To the Hospital

)1888 iam Lee Lan		State	or Print in Black e of Maryland / De	epartme	ent of He	alth and N				000 0355
			1- For State Registrar		Certifica	te of De	ath			g. No.	
Me	Physici dical Exami	41.07	1. Decedent's Name (First, Middle,Law William L. I	,					 Date of Deat Month March 7, 2 	Day Year	3. Time of Death 0322 hrs
			4a. Facility Name (if not institution, g			4b. C	ty, Town, or Loc	cation of Death	Mai Gi 7, 2	4c. County of	Death
			1601 Bruce Court Apt. 4			Ва	ltimore			N/A	
	Funeral Director		216-62-4857	Sex 7. Age (In 5	yrs, last birth			If Under 24Hrs. Hours Min.	-		9. Birthplace (State or Foreign Maryland Country)
	ķ		Usual Residence of Decedent 10a. State 10b. County	100	City, Town o	or Location					10d. Inside City Limits
	nd how ar	<u>.</u>	Maryland N/			timor	е				1 X Yes 2 No
	larylar 28a-f s at on	Director	10e. Street and Number			10f	Zip Code		10	g. Citizen of Wha	at Country?
	15-0036 filed within 72 hours after death with the Maryland Hygiene. sol other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once									USA	
1	ith wit tems 2 st be n	Funeral	11. Marital Status 1 X XNever Married 2 Marrie	12. Was Decedent Ever Armed Forces?	in U.S.		edent of Hispar ecify Cuban, M			- 14. Race - White,	American Indian, Black, etc.
1	ter dea	Fu	10	1 Yes 2XX	No	1 Yes	2 ^X No s	necify:		Specify:	Black
'	ours af atural	d by	15. Decedent's Education (Specify	or Dates:	ed) 16a. D	Decedent's Us	ual Occupation	(Give kind of w	ork done	16b. Kind of Bus	iness/Industry
/	6 172 ha an "nu	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)		-	working life. DO	O NOT use retir	ed)	 Private	Industry
	5-003 iled within Hygiene. I other th the Medi	Completed	9th grade Bricklayer 18.Mother's Name 18.Mot							Anidon Surnamo)	
	MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other that	BeC	Willie Lambert		osa Br	me (First, Middle, Maiden Surname) rown					
	21, rould b id Men is mar tic eve	P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rosa Dickerson/ Mother 3907 Fairfax Road								ber, City or Town	State, Zip Code)
	Maryland N/A Baltimore Maryland N/A Baltimore Maryland N/A Baltimo								Date		City or Town, State
	Baltimore, learnit. Pages 1 and Department of Heal Important: If item injury or other tra		1 Burial 2 Cremation 3		etery/			ore, Maryland			
	Itim iit. Pa irtmen ortant ry or o		4 Donation 5 Other Special 21. Signature of Funeral Service Uco	fy:	Eacility Ch	atman-	Harris	Funeral Home			
	Den Den Injury		Derver Ha	516		5240	Reist	tersto	wn Rd	Baltimo	ore,Md 21215
	Physician	_	23a Part I. Enter the disease, or con failure. List only one cause on	each line.		t enter the mo	de of dying, suc	ch as cardiac or	respiratory arre	est, shock, or hea	Approximate Interval Between Onset and
	/Medical xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)	Cocaine Intoxic							Death
				Due to (or as a consequer	nce of):						
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer	nce of):						
	£.	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):						
	executed an and all - transit	_ ,	,	d							
		dic	X UNPENDED	AMENDED 23a, Pt	t II, 27	7, 28a-f	per ME g	3/18,	/08 amh		
	876 tificate ng phy as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy 2	Fetal de	ath 3 I	Ectopic pregna	ncy	23d. Date of o	delivery Day Year
	ath cer attendi	sicia	past 12 months? 1 Yes 2 No 9 Unknow	Pregnant at time		=				8	·
	The de charter of the de charter of the de f	Phy	Part II. Other significant conditions	9 OHKHOWH	not resulting	in the under	ving cause give	n in Part I.	23e, Did to	bacco use contrib	oute to the cause of death?
	P.C es that igned be deta	ğ	Cirrhosis of Liver	· ·	·		, ,		1 Yes	2 No 3	Probably 4 🗸 Unknown
	rds, requir	letec			-				24a. Was a		ere autopsy findings available for to completion of cause of
	eco he law ate has	24a. Was an autopsy findings performed? 1 Ves 2 No 1 Ves 2									eath?
	25. Was case referred to medical examiner?										
	Physic rthis o	10 B	1 ✓ Yes 2 No	Hospital: 1 Inpatient		tpatient 3				Residence 6	
	n of ding 1 h. After funer	Ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)		ime of Injury	28c. Injury a	t Work? 2 X No		now injury occurre	d
	Division of Vital Records, P.O. Box 68760 at or Attending Physician: The law requires that the death certificate brasher death. "I Director: After this certificate has been signed by the attending physical brasher the funeral director, page 2 should be detached for use as the but	ertification:	2 Accident Investiga	29a Place of Injury		nd 3:00_ rm. street. fac	31 4		Unk 28f. Location (S	Street and Numbe	r or Rural Route Number, City
	Division of Vital Records, P.O. Box 68760, ppital or Attending Physician: The law requires that the death certificate be execut sours after death. reral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the bunal - tran	ertif	3 Suicide 6 X Could no determin	ot be			,	- 1	or Town, S	tate) 1601 Br MD 2121	uce Court Apt. 4
	Division of Vital Records, P.O. Box 68760, To the Itospiral or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buint	O	29a. Certifier 1 Certifying Physi	cîan: To the best of my kno	wledge, dea	th occurred a		and place, and	due to the caus	e(s) and manner	
	To the Hos within 24 h To the Fun completely	Medical		er:On the basis of examinat and manner stated.	ion and/or in	vestigation, i			the time, date		
		2	29b. Signature and title of certifier				29c. License nu	uinber		∠9a. ⊔ate signe	d (Month, Day, Year)

30. Name and address of þerson who con
Ling Li, MD Assistant Med

State
Registrar

31. Date filed (Month, Day, Year)
MAR 1 7 2008

O.C.M.E.

, my

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

March 7, 2008

08-01940 Arthur Lee Long

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Tulur Lee Long		State 1- For State Registrar	e or Maryland / De)	•	ate of Deatl		п пудк	Reg.	No.	2008	3 0855
Physicia	n/	1. Decedent's Name (First, Middle,La	·		T		2. D	ate of Death		Year	3. Time of Death
ledical Examir ್ರೀ	ner	Arthur 4a. Facility Name (if not institution, g	Lee		Lor I4b City T	own, or Location of D	M	lonth D arch 9, 200	08 4c. Cc	ounty of Death	0600 hrs
		2200 blk Edgecombe Cir			Baltim		Jean		10.00	only or boath	
Funeral		5. Social Security Number 6.	Sex 7. Age (In	yrs. last bir				Date of Birth(MM/DD/	YYYY) 9. Birth Foreign	
Director		242-54-9614	X _M 2 F	59	Yrs. Months	s Days Hours	Min.	10 0	2	38 Cou	
any		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town	or Location					- 1	10d. Inside City Limits
* .1		MD NA			altimore	9				j	1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip	Code		10g.	Citizen	of What Count	ry?
th the Maryland 23a or 28a-f sho notified at once.		2528 Edgecomb	Cir. North	า		21215				U.S.A.	
ath with	Funeral	11. Marital Status 1 Never Married 2 XMarrie	12. Was Decedent Ever ed Armed Forces?	in U.S.		nt of Hispanic Origin y Cuban, Mexican, P			14.	Race - Americ White, etc.	an Indian, Black,
her dex			1 Yes 2x I	1 Yes 2			Sp	ec <i>ify:</i> B]	.ack		
ours at at ural xamin	d by	15. Decedent's Education (Specify	or Dates:	Decedent's Usual		done 1	6b. Kind	of Business/In	dustry acquer		
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	12th grade 17. Father's Name (First, Middle, Las	na st) Unknown		Paint	Mixer 18.Mother's	Name (Fire	st, Middle, Ma		nt Con	ipany
215 be file ntal Hy rked o	æ		Olikilowii			Mary	Fax				
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	의	19a. Informant's Name/Relationship				(Street and Number	er or Rural	Route Number			
and 2 sho ealth and tem 27 is fraumati		Helen E. Long 20a. Method of Disposition			of Disposition (Nam		Da Da			Balt1	more, Md Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		1 X Burial 2 Cremation 3			tory or other place) Zion		3/17	100	D - 1	timore	ма
altin mit. Pa partme portan		Donation 5 Other Special 21 is a ture of Funeral Service Lice		PTC	22. Name and	Address of Facility		700	Daı	CIMOLE	e, Mu
E Per E	ŀ	Flyns 13:	Keke		14300 V	F/H Wes Nabash A	ve.	Balti	mor	e, Md	21215
Physician /Medical		23a. art I. E. te the disease, or con ailure. List only one cause on	nplication. That caused the ceach line.	a comp.	ot enter the mode of licated by	of dying, such as care Atherosclere	diac or res Otic C	piratory arrest ardiovas	t, shock, cula	or heart r Diseas	Approximate Interval Between Onset and Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequer c.	nce of):							
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xecute n and l - tran		X UNPENDED	d AMENDED23a,27,	20 £	non ME -070	2 / /0 /00					
760, cate be executed physician and he burial - transit	Medical	IF FEMALE:	23c. If yes, outcome of			5 4/9/06 amn			23d. [Date of delivery	
ox 687 (eath certifica	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal death	3 Ectopic p	oregnancy		1	,	ay Year
Sox leath c e atten for us	Physician/	1 Yes 2 No 9 Unknow	wn 9 Unknown	or death	5 Other (Spe	cify)					
O. B. at the de de de tached f		Part II. Other significant condition	s contributing to death but	not resultin	g in the underlying	cause given in Part	1.	23e. Did toba	acco use	e contribute to t	he cause of death?
F. P.C lires that signed t	d by						_	1 Yes	2 _ N		ably 4 🗸 Unknown
ords w requ	Bet]	24a. Was an autopsy	, i	prior to c	opsy findings available ompletion of cause of
Rec The la cate h	Completed							perform 1 Yes 2		death? 1 ✔ Ye	s 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital:	2		26.Place of Death (C	heck only Nursing He		ooidona	e 6 🗸 Other	Soone
of Ving Phys	£	1 Yes 2 No 27. Manner of Death	28a. Date of Injury			28c. Injury at Work?	280	. Describe ho	w injury	occurred	
ion of tending Pheath.	Certification:	1 Natural 5 Pending 2 X Accident Investiga		End	6.150	1 Yes 2 X N	vh	bject ex ile into	pose	d to colo ted	l temperatures
or Att or Att or Att or Att or Att	ijig	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Right or Town, State) 2200 Block									ral Route Number, City
Dispital hours a neral J	S	4 Homicide									e,MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only Certifying Phys	ner:On the basis of examinat	owledge, de tion and/or	ath occurred at the investigation, in my	e time, date and place y opinion, death occu	e, and due irred at the	to the cause(time, date ar	s) and r	nanner as state , and due to the	ed. e cause(s)
To To com	Med	29b. Signature and title of certifier	and manner stated.	1		c. License number				te signed (Mor	
		Talan.	11,7	1		O.C.M.E.			March	9, 2008	
	ł	30. Name and address of person wh			<i>r</i>	1. B. H	D 6455				
			sistant Medical Exam 32 Registrar's Si		11 Penn Stree	et, Baltimore, Mi	D 21201				
Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 7 2	2008 Sacrates Si	y late	A SOUTH						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 7:40AM 4a Fecility Name (If not institution, give street and number) Levine /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 11 SLADE AVENUE, APT. #816 BALTIMORE PIKESVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Sociel Security Number Days **Funeral** Months Yrs. 88 212-20-0366 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Taturel', or Itams 23a or 28a-f show any injury or other traumetic event. The Medical Examines 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 ☐ Yes 2 No Funeral Director PIKESVILLE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 11 SLADE AVENUE, APT. #816 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 (M Yes 2 □ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education
(Specify only highest grade completed) College (1-4or 5+) 5+ Elementery/Secondary (0-12) MEDICAL PHYSICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be MARY BANK LEVINE SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 11 SLADE AVENUE, APT. #816, PIKESVILLE, MD MARY ELLEN LEVINE / WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 03/14/08 REISTERSTOWN, MD BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Physician/Medical Examiner atteroscleratic coronny or Attending Physician: The law requires thet the death certificete be executed. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events attending physician end for use as the buriel-trer diabetes Division of Vital Records, P.O. Box 68760. resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No 26. Place of Deeth (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: edicai Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this or Atternation of the death. 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 1. Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a. Certifier (Check only one and manner stated. 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signetyre and title of certifier 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 0_{j} 702 W. Yoth St 21211 con 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ARTHA 9.40 AM MARCH 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 12ANDALLS HOSPITAL IDWN BALTIMORE NORTH WEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Year. Months Days Hours Min. 215-12-1429 1 □ M 2 💢 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □ Y*e*s 2 📈 Ño etimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1526 Drive -12 Nilliam 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Newer Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House WIPE NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Dr. (latons vil MD, 2122 Maxine 1526 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State -19-08 Cen 4 Donation 25 Dother (Specify) Nat 21. Signature of Funeral Strvice Licens 22. Name and Address of Facility 23a. Perf. 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or near failure. List only one cause on each line. Immediate use (Final disease of condition resulting in death) cohilih D. 27 Due to (or as a consequence of): Ren Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) neconon! Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Probably 4 ☐Unknown 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f shov edical Examiner must be notifled at

the

traumatic

permit. Pages 1 and 2 shr Department of Health and Important: If Item 27 Is m any injury or other traum: once.

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be onent of Health and Mental

sician and burial-tran attending physician for use as the buria director, page 2 certificate has this

The law requires that the death certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Hospital or Attending Physician:

death.

After 1

within 24 hours after death

To the Funeral Director:
completely filled in by the

Examiner

Physician/Medical

≥

Completed

Be

Certification: To

Medical

State

Registrar

23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 24a. Was an perform 26. Place of Death (Check only one) ax No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature

and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

NORTHWEST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARCH 13 2008 006635=

HUSPI TAL

VENKATA 12EDDIVARI

31. Date filed (Month, Day, Year) 2008 7

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 Month March 14, **Physician** 1:25 A. M Dolores Ellen Mullinix /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson TOWSOII

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year Dec. 17, 1 Gilchrist Center 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2XXF 1929 78 **Director** 217-26-4431 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes AXNo Maryland Howard Woodstock Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21163 1684 Woodstock Road United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Charles Grimes Ella Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Alvin Mullinix / Husband 1684 Woodstock Road Woodstock, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 18, 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. PK. 2008 Glen Burnie, MD 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A.
421 Crain Hwy. S.E. Glen Burnie, MD 21061 of Funeral Service Licensee 21. Signature 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only in a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 687607 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2: performed 2 No To the Hospital or Attending Physiclan: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MArch 14, 2008 N. Charles St. Balto Md 2,208 and address of person who completed cause of death (Item 23a) (Type, Print) 6781 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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Physician

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Important: If item 27 is
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Certification:

Medical

29b. Signature and title of certifier

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: To the Hospital or within 24 hours afte To the Funeral Di completely filled in

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension, Rheumatoid tophaceous 25. Was case referred to medical examiner? examiner? 1 ☐ Yes 2 No Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\triangle \text{ Residence} \) 6 \(\triangle \text{Other} \((Specify) \) epital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)
P 20966 March , 10 , 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Balhmore, MD, Z1279 900 \$ 5. Caton 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕕 🖯 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 05:41 PM TIMOTHY MONTAGUE MARCH 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 3, 19 **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 M 2 □ F 43 Director 216-82-3582 1965 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Director 1 ☐Yes 2 ☐ No Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 1153 Seneca Road 21220 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian th and Mental Hygiene. 7 is marked other than "natural", or iten traumatic event, the Medical Examiner permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If flem 27 is marked out. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No þ Specify: Specify. 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 12 Medical Transcriptions 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Montague ၉ Celaine Sommer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debi L. Montaque / Wife 1153 Seneca Road Middle River, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Church Cem. 3/18/08 Phoenix, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road La. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTI ORGAN PAILURE 7 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the ed by the attending detached for use as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 💢 No autopsy 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ၉ 1 ☐ Yes 2 🕱 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturai 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attendent within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

NADYA

31. Date filed (Month, Day, Year) MAR 17



AVERBALLE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Willie Morris McGee 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Square anklin oso da Baltimore Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 11/22/1929 cial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) Days 1XM 2□ F Hours 215-24-2218 78 North Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2XNo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 N. Stuart Street 21221 S. A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: American 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembler Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie McGee Ellen Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Lee McGee (Wife) 627 N. Stuart Street Essex, Maryland 21221 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3608 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licensee Luchael C. 1407 Old Eastern Avenue Sr. 2 affers Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardiac or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mbolisi Umonary Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Physician /Medical Examiner

Examine

Physician/Medical

Be Completed by

Certification: To

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Physician

/Medical

Examiner

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by Funeral

Completed

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Funeral

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show

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

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Injury or other traumatic event,

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MCGE, WILLIE Baltimore, Maryland 21215-0036

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certificate be executed ed by the a funeral director, this After 1 Hospital or Attending within 24 hours after death. To the Funeral Director; filled in by

Box 68760,

P.0.

Division or Vital Records,

completely 16

29b. Signature and title of certifier 30. Name and address of person who cou

6 Could not be determined

29c. License number D0065094

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

pleted cluse of death (Item 23a) (Type, Print)

Dr. Binh Nguyen
31. Date filed (Month, Day, Year) Ø000 Franklin Square Drive Baltimore, Maryland 21237 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** February 29, 2008 9:15 AM M Loren R. Marsh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore 6828 Park Forrest Lane Hydes 8. Date of Birth (Month, Day, Year Mar 25, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□F Yrs 388-24-9822 77 1930 Wisconsin Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Hydes MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6828 Park Forrest Lane 21082 USA death Funerai Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white þ 3 Widowed 4 Divorced 47-67 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk other than Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>logistics</u> specialist 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked other any liquy or other traumatic event size. 17. Father's Name (First, Middle, Last) Be Joseph Nicholas Miller Elizabeth Mary Even 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anneliese Marsh/spouse 6828 Park Forrest Lane Hydes, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Septice Licensee, Ronald S, Wade, State Anatomy Board 655 W. Baltimore Street Director m 21201 Baltimore, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician months Non Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Oate of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28d. Describe how injury occurred After 1 Maturat 5 Pending s effer dea. ral Diractor: Afr 1 Yes 2 No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 1650 Orleans Street Boltmore Maryland 2121 31. Date filed (Menth Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryla		rtificate of l			00000	00550
			Registrar 1. Decedent's Name (First, Middle, La	ast)		timodic or i		2. Date of Death	. No. /	3. Time of Death
	Physicia		Thomas	8 Mark				Month	Day Year	8 10:55AM
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death	Marcic	4c. County of Dea	
)	Examin	er	2752 Kick	Leinh Ropa	/	Dieki	dalk		Bal	imore.
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yi	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,)	9. Bi	rthplace (State or Foreign
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	r iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, Wh	ite, etc.
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	- D 66	Medi	IS SEAMLE.							
X Q Q	death certif e attending d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of d	
5	e dea he at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown		Other (specify)			Month	Day Year
Į.	w requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions	contributing to death but not a	coulting in the u	ndorlying sauna giv	on in Port I	22a Did toha	oco use contribute	to the cause of death?
Š,	requires that een signed b nould be deta	by	Fait II. Other significant conditions	contributing to death but not i	esulang in the di	nderlying cause giv	ciriii raiti.	1 €Yes		Probably 4 □Unknown
Ö	requ	eted								
ıtaı Kecords,	The law te has b	Completed						24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
0	(0)		05.14					1 Yes 2	No 1 □Ye	
5		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	□ EP/Outpation	othor Othor	or:	h (Check only one)		
Ö	ding Phys n. After this funeral di		27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe how	ce 6 Other (Sp injury occurred	есіту)
0	ttending Ph teath. tor: After th the funeral	tior	Natural 5 Pending 2 Accident investigation	(Month, Day Year)) Injury		k? Yes 2 □ No			
IVISION	al or Attending F s after death. il Director: After id in by the funera	ifice	3 Suicide 6 Could not to determined		t home, farm, str	eet, factory, office		28f. Location (Stre		Rural Route Number,
5	tal or 's afte al Dir	Certification:		Danamy, etc. (eps				ony or rown,	otato)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exa	hysician: To the best of my kaminer: On the basis of exami	knowledge, death ination and/or in	n occurred at the tir vestigation, in my o	me, date and place, ppinion, death occur	and due to the cau	use(s) and manner a te and place, and d	as stated. ue to the cause(s)
	the hin 2, the mplet	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	20/	d. Date signed (Moi	nth Day Year)
	0 = 0 0	_	29b. Signature and title of certifier	el a cla					3/13/108	mi, Day, Touty
	F 3 F 8		L 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					-	11 / T / UX	
			In furtely,	X	Clan (Tuna	D19-	117		113/ 0	
	9		30. Name and address of person who	completed cause of death (It	tem 23a) (Type,	Print)				1224
*		te_	30. Name and address of person who M LHATEL PURTE 31. Date filed (Month, Day, Year)	completed cause of death (It	tem 23a) (Type,	Print)			e, me zi	114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 03 Day 13 2008 Lillie Mae Moore 10:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Futurecare Sandtown Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 219-30-9184 1 M 2 XF unk March 11, Director 97 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the IM dical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Funeral Director 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1947 West Lafayette Avenue 21217 TISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Black 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic housekeeper unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Sarah Stokes ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clarice Allen / Great Niece 1947 W. Lafayette Avenue; Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mount Zion Cemetery 03/20/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. 22. Name and Address of Facility 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 17, /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ing physician ar Due to (or as a consequence of). P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? 2 No 2 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA Medical Certification: To 1 Inpatient 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar 32 Registrar's Signature

Distant.

29c, License number

D31865

30. Name and address of person who completed capse of death (Item 23a) (Type, Print)

2008

206

29b. Signature and title of certifier

31. Date filed (Month)

Battonere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Maryland /	Depa Cer	artment o	of Hea of Dea	lth and N ath	Mental Hy	giene	2008	08561
	Dharaia		1. Decedent's Name (First, Middle,	Last)						2. Date of De	eath Day	Year	3. Time of Death
	Physic /Medi		George H. Norri	Ls						March			3:20 AM M
7	Exami		4a. Facility Name (If not institution,		iber)		4b. City, To	wn, or Loca	ation of Death		4c. C	ounty of Deat	h
			7412 Round Hill					deric		,		rederi	
п	Funeral			5. Sex 7 1 ☑ M 2 ☐ F	7. Age (In yrs. last i	birthday) Yrs.	If Under 1 \ Months D		Jnder 24 Hrs. ours Min.	8. Date of Bi			hplace (State or Foreign untry)
	Director		220-05-4768 Usuel Residence of Decedent	A	86	113.				Apr 6	1921	Mar	yland
	land		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Limits
	Mary	to	MD Freder	rick		Fred	erick						1 ☐ Yes 2 No
	r 28s	rec	10e. Street and Number				10f. Zip Co	ode			10g. Citize	en of What Co	untry?
	within 72 hours after death with the Maryland sne. than "natural", or items 23e or 28e-f show ha Medical Examinat must be notified at	Completed by Funeral Director	7412 Round Hill	L Road				21	702			USA	
	deat	ner	11. Marital Status	12. Was Deced	dent Ever in U.S.	13.	Was Deceden	t ol Hispan	nic Origin? (Sp	pecify Yes or No Rican, etc.)	0- 14	Race - Ame	
9	or the	E	1 ☐ Never Married 2 ☑ Marrie	d 1 1 Yes	2 □ No tes: ¶43–46	1	il Tes, specily 1 ☐ Yes 2 <mark>X</mark>		exican, гоенс pecify:	nican, eic.)		Black, White	
93	iral',	d b	3 Widowed 4 Divorced	Year or Da	tes: 1 43–46		103 ZA	J 110 Op				Specify: wh	
<u>7</u>	nate	ete	15. Decedent's (Specify only highest	Education grade completed)	16	(Give	dent's Usual (kind of work of DO NOT use i	done during		king	16b. Kind	d of Business/	Industry
12	withir ane. Ithan	m d	Elementary/Secondary (0-12)	College (1-	4or 5+)	me.		,					
2	Hygie ther		17. Father's Name (First, Middle, Li				engin		Mother's Nam	ne (First, Middle			nications
an	d be antal	To Be	George Howard					-		iola Hi			
Maryland 21215-0036	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or items sumatic event, the Medical Examinating.	F	19a. Informant's Name/Relationshi		1:	9b. Mailir	na Address (S			ral Route Numb			Zip Code)
S	and 2 : Balth ar n 27 io		Iris Norris/sp	ouse						Freder			
ē,	r Heal	100	20a. Method of Disposition		20b. Place	of Dispo	sition (Name	of		Date	20c. Loca	ation - City or	Town, State
e E	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe		State	сөгү, стөг	natory`or othe	n piace)	i				
Baltimore,	그 문문을 .		21. Signal are of Funeral S, rvice Li			022	Name and	Address of	Facility	l 655 W.	D - 1 4	•	Chara
ä	Depa Impo any to		Monard S	/1/29 Mi	rector		ate An Itimor				ватт	imore	Street
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that ca	used the death. D						rrest,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition			4/	Acre		Dus	EASE			Onset and Death
	/Medical		resulting in death)	a. Due to (c	RONAR or as a consequence	e of):	ICIR	ry					10 /103
	Examiner		Sequentially list conditions	h									
	D ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (a	or as a consequenc	e ol).							
	and and ill-trans	саш	that initiated events resulting in death) Last	c.		0:						_	
8760,	cate be executed physicien and the burial-transit	E		Dua to (c	or as a consequenc	e or):							
87	ate hys	Physiclan/Medical Examiner	•	d									
9 x	eath certific attending p I for use as I	/Me	IF FEMALE:	23c. If yes, outc	ome of pregnancy						20	od Data of dal	
Вох	eath atter for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live bit	nth 2 🗌 Fetel dea		Ectopic pregi				23	Rd. Date of del Month	Day Year
o.	that the ded by the detached	ysi	1	9□ Unkno			a cirior (open.						
<u>α</u>	res that signed b be deta		Part II. Other significant condition	s contributing to dea	ath but not resulting	g in the u	nderlying caus	se given in	Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
of Vital Records,	n sig	d by	ATRIAL FLUTT	ec, Sice	c SIKUS	Syn	DROME	_ , #	PPERTE	nsion 10	Yes 2□	No 3□Pr	obably 4 Honknown
00	s been si should	Completed	HYPOTHYROID					•	1	24a. Was		24b. Were au	itopsy findings available
æ	The lav	E O								auto perf	ormed? 2€No	prior to death?	completion of cause of
Ital		0	25. Was case referred to medical				-,710	26.	Place of Dea	th Check only	-	1 🗀 163	20140
>	Physician: this certificanal director,	ToB	examiner? 1 Tyes 2 No	Hospital: 1 ☐ In	patient 2 ERV	Outpatier	it 3□ DOA	Othon		ome 5 Pres		☐Other (Spe	cify)
0			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of	f Injury 28b	Time of	28c	. Injury at Work?		28d. Describe	how injury	occurred	
Ö	Attending r death. ector: Atter by the fune	atic	2 ☐ Accident investiga	ition	, , ,	,,	М	1 🗌 Yes	2 □No				
Division	or Attendation of the or Attendation of the order or I in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	259. Flace	of Injury - At home, g, etc. (Specify)	larm, str	eet, factory, o	ffice			(Street and wn, State)	Number or Ru	ural Route Number,
	ospital or A hours after uneral Directly filled in by	S											
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledicai	(Check only 2 Medical Ex	Physician: To the li xaminer: On the ba	sis of examination a	lge, deatl and/or in	n occurred at t vestigation, in	the time, da my opinior	ate and place, n, death occui	, and due to the rred at the time	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	To the H within 24 To the Fi complete	Med	one) 29b. Signature and title of certifier	and manne	er stated.		290 1	icense nur	mher		30d Data	signed (Monta	h New Year)
)	Z 2 2 8	-	A Dre	lum N	11)			2193				10/0	
			20 Name and address	ho completed as	ad death (he iii Co	\ C*							
			30. Name and address of person w ANDREW DONE	1	65 C 7	HOY	nas U	10 HAS	son W	R. FR.	EDER	LICK	21702
	Sta	ite	31. Date filed (Month, Day, Year)	2008 32	gistrar's Signatura		rest						
	Registi		MAR 1 (2000	TOWN SO	A	1						

State Registrar 29b. Signature and title of certifier

ABDALLAH 31. Date filed (Month, Day, Year)

Helou, M. D.

M.

M. D. 76 VII 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELOU

2008

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OSLER

29c. License number

DØØ17695

DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

March 13,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 08004 W Omps Leotta Anna 2008 Larch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, O9 10 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF Months 82 208-24-4962 Yrs. WV Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Worle r than "naturel", or items 23s or 28e-f ehov the Nedical Examiner must be confided at NA Baltimore 1X Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 10 South Athol Street 21229 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nt: if item 27 ie marked other than "naturel", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: þ 3 ☐ Widowed 4 ♥ Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Coffege (1-4or 5+) Unk Elementary/Secondary (0-12) Cook Restaurant other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Decker Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leotta Omps-Daughter 117 Carriage Lane, Concord, VA 24538 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Depertment of Important: if it eny injury or o Burial 2 Cremation 3 Removal from State 4 Ponation 5 Other (Specify) Mt. Carmel 3/14/08 Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Cagain flany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine signed by the attending physicien and the bedeached for use as the burial transit certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 28 No 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ER/Outpatient 3 DOA After this 28b. Time of Injury 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. the ch 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 1 2220 D. N me and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) MAR 1 7 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 12:05 A M Robert Arthur Plews March 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Chesapeake Hospice House Linthicum If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 1 € M 2 □ F 18, Director 1936 Maryland 212-32-7863 Usual Residence of Decedent Maryland 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Anne Arundel <u>Glen</u> Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Cedar Drive 21060 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify \$ 3 Widowed 4 Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within .
Department of Health and Mental Hygiene .
Important: If item 27 is marked other than "i any injury or other traumatic event; the Meo once. than Elementary/Secondary (0-12) College (1-4or 5+) Store Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Richard Graham Plews Maude Helen Kremer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Cedar Dr, Glen Burnie, MD 21060 Peggy A. Plews / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March, 14 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2008 Glen Burnie, Maryland Glen Haven Mem. Park 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. o Funeral vice Lin nsee 21. Signature 0 Crain Hwy. S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or combifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 1000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760完 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 🗌 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑Other (Specify)Hospice 1 Yes 2 No ျ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 🙀 Natural Injury 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident after death.

I Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Russell R. DeLuca,
31. Date filed (Month, Day, Year)

MAR 1 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 305 Hospital Drive, Glen Burnie, MD 32 Registrar's Signature

DHMH 17 Rev 1/2001

21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 0200 AM 3 14 2008 Lorraine Peyton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKUN Square Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F Director 214-50-7451 Pennsylvania 12/12/1947 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 S. Hawthorn Road Completed by Funeral 21220 Α. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ William Nunmaker (unknown) Mildred 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25 S. Hawthorn Road Middle River, Maryland 21220 William Henry Peyton (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/18/2008 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Gardens Baltimore, Maryland 21. Signature of Furteral Service 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREUMOCOCCAL Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause Frier Ladenying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Physician /Medical Examiner The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar models.

land

Baltimore,

signed in by the funeral director,

Attending Physician:

To the Hospital of within 24 hours at To the Funeral D State Registrar

Medical

29a, Certifier

29b. Signature and the of certified

DR Saman Tha Dreyer 31. Date filed (Month, Day, Year) MAR 1 7 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 4-2003 066306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square 21237 DR md Balto 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Olive S. Rinehart /Medical March 2008 10:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson <u>Baltimore</u> 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 85 Yrs. Director 185-12-0019 01/10/1923 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified Director 1 ☐ Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Ave, Apt. 1413 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 □ Yes 2 🛛 No Specify: þ Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Public Schools <u>Administrative Asst.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Stumpf <u>Jean Swayne</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Rinehart/Son 162 Tuscan Circle, Jupiter, Fl 33458 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Hilltop Service Corboration permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, 03/15/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral 21. Signature of Juneral Service Licensee Inc. 1050 York Road, Towson, MD 81894 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Oroph Avyngent weeks resulting in death) /Medical Due to (or as a consequence of): **Examiner** Severe Debilit if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Osteoporosis with Kyphosis ice of): And restrictine Lungdisense Completed by Physician/Medical Exami Severe attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? welundisease 1 🗌 Yes 2 No 3 Probably 4 Unknown Fracture 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.
To the Funeral Director: After this ocompletely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Fell while going To The Bothers of resulted in Left Les Fronten 281. Location (Street and Number or Rural Route Number, City or Town, State) 5 Pending investigation 1 Natural 9:00 PM 1 ☐ Yes 2 🗷 No February 28, 2008 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Apartment - Bathroom 615 Chest not Ave. Towson, md 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mprch 13, 2008

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. R. Vey GBMC 6701 N. Chaul 6701 N. Charles St. Balto Md 21204 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** NANCY RAYFORN MARCH 04 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE HEALTH STITE 2001 BALTIMORE SI x HSZComs If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Pay,
17 02 07 07 07 11-5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 F Director 250-34-9716 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show at items 23a or 28a-f shiner must be notified MUD 1√ Yes 2 No BALTINORE Director AlTIMORE 10e. Street and Number 10g. Citizen of What Country? USX 2 should be filed within 72 hours after death is and Mental Hygiene.

Is marked other than "natural", or Items 23straumatic event, the Medical Examiner must by Funeral 1217 W. Fayette Street 21223 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 X Widowed 4 □ Divorced black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk Pages 1 and 2 should be nent of Health and Mental or other traumatic ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trainonce. Bon Secours Hospital 2000 W. Baltimore Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signature o Konali S. Wad, Wirector State Anatomy Board 655 W. Baltimore Street m Baltimore, MD 23a. Parts. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Examiner CARDIAL Sequentially list conditions, if any 1-2 in 1-2 in in a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ARTERIOSCLEROTIC HEART DISEASE be executed burial-transit and attending physician Physician/Medical as the I use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten e detached for u 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 210 No P 1 🗌 Yes funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1.2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760 Records, Division or Vital To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

State

MAR 1 Registrar

(Check only one)

29b. Signature and title of certifier

ND

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

D 23300

MARCH

BUN SELOURS 7965P.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUDN, BALTO ST. SUDKIR D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nd. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 13, 2008 Bertina Victoria Simpson 1:25P. M Mar. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 86 Director 20,1921 214-16-9766 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f shovedical Examiner must be notified at Towson Baltimore Director 1 ☐ Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 345 Eudowood Lane 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 21215-0036 1 ☐ Yes ¾ No Specify: ρ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)
Custodian Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other that any injury or other traumatic event, the agree. 11/2 16. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isabell Smith Sylvester Anderson 19a. Informant's Name/Relationship (Type. Print)

Delphine Anderson/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

345 Eudowood Lane Towson, Maryland 21286 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant Rest Cemetery 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Md 21215 23a. Part Fifer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (inal disease or condition resulting in death)

a. Districtions Approximate Interval Between Onset and Death **Physician** weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and the death certificate be executed Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) o. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed Ancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1∐ Yes or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MArch 13, 2008

State Registrar

1

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

hayles St. Balto and ZIZOY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Philemia Mary Seabrease 14,2008 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center Baltimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 1,1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□ M 2 T□ F Months Days Hours Min. 214-22-2292 Maryland 94 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ **X**No Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Lisa Court 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Not Available Ranalli Mary Not Available 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Atherton Road Lutherville, Maryland 21093 Christina Weinman Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 3-19-2008 Baltimore Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive disease or condition resulting in death) Due to (or consequence of): Ar oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Directo

Funeral

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Completed

Be ဥ

Funeral

Director

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n

of Health

Pages 1 Department of Important: If It any Injury or o

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by

Be

Certification: To

Medical

2

29a. Certifier

29b. Signature and title of certified

sician and burial-trans physician the the ģ

The law requires that the death certificate be executed

To the Hospital or Attending nours after death.

neral Director: /

within 24 hours a To the Funeral L

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year				
Part II. Other significant conditions Atrial Fibr	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown					
		24a. Was an autopsy performed? 1□ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 XNo				
25. Was case referred to medical examiner?	26. Place of Dea	Check onl one				
1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death 1 Natural 5 Pending investigati		28d. Describe how injury occurred				
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)				

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

760100ler Drive, Towson, Maryland 21204

29d. Date signed (Month, Day, Year)

M. Joainder Mehta 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 17 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lorraine Turner /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town,/or Location of Death 4c. County of Death Examiner GRARRAL TIMORE Birthplace (State or Foreign Country) 5. Social Security Number Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 21, 1928 6. Sex 7. Age (In vrs. last hirthday **Funeral** 1 M 2 X 220-20-4219 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show Examiner must be notified at MD Baltimore Director 1177 Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1617 N. Bond Street 21213 "natural", or items 23a TISA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 ☐ Widowed 4 K Divorced Year or Dates: Completed the Modical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) teacher's aide Baltimore City School System Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Columbus Hill Francis Armstrong 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Russell / Nephew permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra 7775 Beadfield Sourt; Mannassas, VA 20112 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 03/15/2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 .23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran P.O. Box 68760. Physician/Medical use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 ☐ I certificate 2 ☐ No Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Certification: To 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and addr ss of person who compl use of death() item 23a) (Type, Print 31. Date filed (Month, Day, Year) State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Woll (4:10 AM ausi elma March 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Evaminer Havan. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. General Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number Funeral 1 □ M 2 😿 F Months Davs Hours Min 75 Mar 1, 1933 Pennsylvania Director 199-28-3760 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐Yes 2√ No MD Howard Columbia Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5230 Eliot's Oak Road 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 □ Never Married 21X Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) teacher/homemaker education/own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Walter Vause Geoffrie McCoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl M. Walls/spouse 5230 Eliot's Oak Road Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade /Director Baltimore, MD 2120123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final disease or condition resulting in death) **Physician** 10 socomia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or our rying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Lie 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours at To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifiei Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CH/e 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 40 A M 50 Tarc 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Walther hmore ear If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**№**M 2□F Months Days Hours Min. -2010 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 PNo Director Immore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be 8810 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Evel Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ş Specify: 3 ☐ Widowed 4 ☐ Divorced White KOREA Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 50R lesting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12 34 19a. Informant's Name/Relationship (Type. Print) 8810 Baltimore, MD 1 ther 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 3 ☐Removal from State 4 ☐Donation 5 Other (Specify) VICUI (/ CMM HOLY : 22. Name and Address / Facility 21. Signature of Funeral Rd. 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending plant for use as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached to ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1XYes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1∐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and

2. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

WAIERFIELD

Weinberg

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				For State	State of Ma	•	epartment of		Mental H	ygiene	9	
				Registrar 1. Decedent's Name (First, Middle,			Certificate of	Death	O Data of D	Reg. No.	2008	0.8573
		Physic		Calvin	E.		Ziegler	Jr.	2. Date of D Month O3	11 ^{Day}	y 2008	3. Time of Death 6:45p. M
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		Funeral Director		216-34-4294	10X M 2□ E	(In yrs. last birti	nday) If Under 1 Year Months Days			irth Day, Year) 2 6	9. Bird Co	thplace (State or Foreign buntry) MD
		land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
		Mary F sh	ţò	MD NA		Bal	timore					1 ⊈ Yes 2 □ No
		or 28	Sirec	10e. Street and Number	L		10f. Zip Code			10g. Cit	izen of What Co	ountry?
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1, 20		and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship Terry Ziegler		10.	Mailing Address (Stree 33 East 2	17th St		Bron	ız, NY	10469
CH 1	Baltimore,	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1	Disposition (Name of crematory or other plants Zion		Date 5/08		cation - City or	
MARCH	Balt	permit. Departr Importa any inji		21. Sensure of Funeral Service Lic	ensee Onumpai	4-	22. Name and Addr. March F/ 4300 Wab	ess of Facility H West ash Ave	, Balt	imor	e, Md	21215
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	Ω̈́	pital or A	I Certii	4 Homicide determine 29a, Certifier 1 Certifying	building, etc. Physician: To the best of	(Specify)		ime date and plac	City or To	wn, State)	
		the Hos in 24 ho he Fun ipletely	Medical		aminer: On the basis of and manner state	examination and						
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		3		30. Name and address of person wh				PTWONTING	MD 010	0.2		
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	Div	Registr		MAR 1 7 200	DD 2300 DUL 32. Registrar	N. W.						

DHMH 17 Rev 1/2001

CALVIN ZIEGLER

		For State Registrar	State of Maryland	•	nt of Health a ate of Death	ind Mental Hy	/giene Reg. No. 🥱 💍 🗀	0 00571
Physic	ian	Decedent's Name (First, Middle, Las	_			2. Date of Domestin	eath L Yea	
/Medi	cal	4a. Facility Name (If not institution, give	ZINSER street and number)	4b. Cit	y, Town, or Location o		4c. County of De	, 0
Exami	ner	FRANKLIN Square		nter	Rosedo	ele	Balt	imore
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	last birthday) If Unc	er 1 Year If Under 2 s Days Hours	24 Hrs. 8. Date of Bi Min. (Month, D	irth 9. E	Birthplace (State or Foreign Country)
Director		217-20-3204	M 2004	30 Yrs.	Jayo House	April 1.	3,1927	ND
pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
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h the Marylan r 28a-f show r notified at	Director	10e. Street and Number		10f. 2	Zip Code		10g. Citizen of What	Country?
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d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dec	cedent of Hispanic Original	gin? (Specify Yes or N , Puerto Rican, etc.)	o- 14. Race - Ai Black, W	merican Indian, hite, etc.
after or ite		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No		2 No Specify:	,		ukite
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Maryland d 2 should be file th and Mental Hy ?? is marked oth traumatic event	-	19a. Informant's Name/Relationship (7		19b. Mailing Addre			ber, City or Town, State	e, Zip Code) 2/12/2
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Balt permit. Departi Importa		21. Signature of Funeral Service Licen	300	1/	and Address of Facilit	Bradle	4-HSLHO	N FUNERAL
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Bo eath atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		pregnancy (specify)		Month	Day Year
the d	ysi	9 Unknown	9□Unknown					
Division or Vital Records, P.O. Box to Attending Physician: The law requires that the death cer after death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	by PI	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the underlyin	g cause given in Part I			e to the cause of death?
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or Vital Rec Physician: The lav this certificate has ral director, page 2	Completed					pei 1□ Yes	rformed? deat	h? Yes 2□ No
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hysla hysla this c	2	1 Yes 2 No		ER/Outpatient 3 28b. Time of			e how injury occurred	Specify)
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Div A after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specif	(y)		City or I	own, State)	
Division or Vital Records, P.O. Box 68760, Activities the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the time, date ar	nd place, and due to the ath occurred at the time	ne cause(s) and manne ne, date and place, and	er as stated. due to the cause(s)
o the ithin 2 o the	Medical	one) 29b. Signature and title of certifier	and mariner stated.		29c. License number		29d. Date signed (M	fonth, Day, Year)
, , , ,)///	•		D006:	3974	3/11/8	8
3		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	- 6	117	1 /	
		1/			in Squa	re DR 1	Balto m	d 21237
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa					
Regis	trar	MAD 1 7 2008	是 是	ALLOW STORY				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 25 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MO Medical Center of 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🔀 F 50 Yrs. 212-23-9975 Director 10/30/1957 Nigeria Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show at r 28a-f sh notified Md. 1 ☐Yes 2XINo Director Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or 2 ifner must be n Pages 1 and 2 should be filed within 72 hours after death with ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or items or other traumatic event, the Medical Examiner must be in 20783 9400 Adelphi Rd. Apt# 3 Nigeria Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jewish Foundation Direct Care Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Akinmuko Abraham Akinmuko Sholape ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai 9400 Adelphi Rd. Apt#3 Hyattsville,Md. Mutairu Akanbi Raji/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Maryland National 3/8/08 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service License 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic plan cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate death? 1 ☐ Yes 2 ☐ No 2X No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient ဥ 1 🔲 Yes 2 ER/Outpatient 3□ DOA After this 27. Mannet of Death 1 ☑ Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: pletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannes stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008

State Registrar

a 31. Date filed (Month, Day, Year)
r MAK 0 5 ZUUG

32. Registrar's Signature

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene [Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Feb 2008 Physician 9:40 A M Hazel Catherine Avey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hagerstown 655 Security Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 15 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Davs Hours 1 M 20 F Maryland 1912 95 Director 217-30-6555 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State in than "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2√☐ No Maryland Washington Hagerstown Directo 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 920 Marion Street 21740 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Personal Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd Mental I Sarah Kidwaller Mason William H. Mason ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health i Marian J. Kinsey - daughter 655 Security Food Magerstown Maryland 21740 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ō <u>=</u> 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Cedar Lawn Mem Park Mar 4 2008 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses any ir 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Kaite 2 23a. Pert1. Enter the disease, excemplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lemon tra Immediate Cause (Final ears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Completed by Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Ped S 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sign De 2 2 No 3 Probably 4 Unknown 1 ☐ Yes should should 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No Division of Vital To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pendina 1 Yes 2 No death. investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a
To the Funerel (
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title person who completed cause ordeath (Item 23a) (Type, Print) . Date filed (Month. Day, Year) State Registrar

			1 - For State Registrar	State of Maryland / De <i>C</i>	partment of F ertificate of I		tal Hygiei Reg.	4.20	5 0837	1
	Physici	an	1. Decedent's Name (First, Middle, Last) ACQUELINE	ANDER	\A ()2		Date of Death		3. Time of Death	1
5	/Medio	cal	4a. Facility Name (If not institution, give str			r Location of Death		4c. County of	1430	M
	LAdinii	iei	Anne Arundel Medi		Annapol			Anne A		
	Funeral		5. Social Security Number 6. Sex 114-46-1427	7. Age (In yrs. last birthda	Months Days	If Under 24 Hrs. 8. C	ate of Birth Month, Day, Ye	ar) 9.	Birthplace (State or Fore Country)	ign
	Director		Usual Residence of Decedent	66 Yrs.		Ma	ay 16,	1941 N	est Virginia	<u>a</u>
	nyland how		10a. State 10b. County	10c. City, Town or					10d. Inside City Limi	its
	Ba-f s	Director	MD Anne Arun	del Annap	O11S				1 Yes 2 ☐ I	40
	with the Paris	Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of Wha		
	ne 23	Funeral	20 Wainwright Driv		214 3 Was Decedent of H		Ves or No-	US.	American Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "natural", or Iteme 23a or 28a-f show eny Injury or other treumatic event, Ita Medical Examinar must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Specify an, Mexican, Puerto Ricar Specify:	n, etc.)		White, etc. White	
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Maryland	2 sho and l		19a. Informant's Name/Relationship (Type			and Number or Rural Ro				
e,	1 and Health em 27 ther t		Eva Renee Anderson/ 20a. Method of Disposition		Thor Bridg		verna F			
altimore,	t. Pages rtment of rtent: If the		1 Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		position (Name of rematory or other plac ren Memoria	2008			rnie, MD	
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			23a. Part1. Enter the disease, or complica	tions that caused the death. Do not e		Ritchie Hwy. g. such as cardiac or res		na Parl	Approximate	_
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	C.A.LuNG					Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					1	
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J.	by the	Physician/M	9 □ Unknown	9□ Unknown						
_	res thet the de signed by the a be detached f	<u>م</u>	Part II. Other significant conditions contri	outing to death but not resulting in the	underlying cause give	en in Part I.		o use contribu	te to the cause of death?	
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ě	The law sete has by page 2 s	Completed				2	24a. Was an autopsy performed	prior	e autopsy findings availab to completion of cause o	ile f
VITa		ø l	25. Was case referred to medical			26. Place of Death /Che	☐ Yes 2		Yes 2□ No	
<u> </u>	Physician: this certifical al director.	ToB	examiner?	pital: 1 Inpatient 2 ☐ ER/Outpati	ent 3 DOA Othe			6 □Other (Specify)	
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DIVISION	Vitendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	OR a Disea of Joiney. At home form		fes 2 □No			0.10	
≥	5 g ig c	Certification:	4 Homicide determined	 Place of Injury - At home, farm, s building, etc. (Specify) 	street, ractory, office		city or Town, St		r Rural Route Number,	
	To the Hospitel or within 24 hours after the Funerel Dir completely filled in		29a. Certifier 1 Certifying Physic: (Check only 2 Medical Examiner	an: To the best of my knowledge, de	ath occurred at the tim	e, date and place, and d	ue to the cause	(s) and manne	r as stated.	
	the h hin 24 the F mplete	Medical	- A -	On the basis of examination and/or and manner stated.						
i	5 × 5 × 5	-	29b. Signature and title of dertifier	Del Contario	29c. License	7 1128	29d. (Date signed (M	onth, Day, Year)	rs.
	2.00	V	30. Name and address of person who confi	eleted cause of death (Item 23a) (Typi	a Printh '	סנ דיע		SOLI	jary as ju	8
	M		MICHAR J. Late	N TH M YY	5 Deren	SE HGHWI	any ANO	VAPOLI	MOZIEN	
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State of Maryland	Department of Health	and Mental Hygien

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		9	Registrar 1. Decedent's Nan	ne (First, Middle, L	a <i>st</i>)							2. Date of De	eath	-	10	3. Time of D	Death
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)	Examin	er		(If not institution, gi	ive street and nu	umber)			ity, Town, o		of Death			. County o			
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	D		Usual Residence of	of Decedent		140		1 4								04 1-14-04	
	arylar show	ř	10a. State	10b. County			c. City, Town or								1	0d. Inside City 1 ☐ Yes	
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	should be filed within 72 hours after death with the Maryland ind Mental Hygjene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status		12. Was Dec		r in U.S. 1	3. Was De	cedent of H	lispanic Or an. Mexica	rigin? (Spe	cify Yes or No	0-		- Americ	an Indian,	
0	s after or ite	by Fu		rried 2 Married	1 □ Yes If Yes, G	2 X No live			2 X No	Specify.		, 0.0.,		Specify:			
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ž	hould id Mer marke	ဥ		Name/Relationship	(Type Print)		19b Ma	ilina Addr	ess (Street			l Route Numl	her City	or Town S	State Zin	Code)	
2	nd 2 saith ar 27 is r trau			Alasha/s								minste					
ב ב	of Hei		20a. Method of Dis	•	ΠB	2	20b. Place of Dis	position (Name of or other place	ce)	D	ate	20c. L	ocation - 0	City or To	wn, State	
Daltillo	Pag ment ant: I			Premation 3 5 ☐ Other (Spec		Cale	Chesapea							tsvi1		And the second	
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	uneral Service Lice	ensee	11						Servi					
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2	pital c		29a. Certifier	1 XCertifying F	hyelejan. To th	no host of m	v knowledge de	ath occur	red at the ti	mo data a	nd place of	and due to the	2 221122	a) and man		totad	
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3)	rês.		30. Name Ind add	dress of person who Middleton	completed cau	3337 \	(Item 23a) (Typ /ictory	e, Print) St .	Manch	ester	, MD	21102					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 26, 2008 С. Barbour February 2049 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | II Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Birthplace (State or Foreign Country) 1X M 2 F 577-20-8256 Yrs. 90 Director 08-16-1917 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?] is marked other then "natural", or iteme 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director ME Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 2506 Queens Chapel Road #201 20782 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Ingalls Steel Company 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H ant: If Item 27 is marked oth Bossie Barbour Lizzie Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxie A. Barbour/Wife 2506 Queens Chapel Road #201 Hyattsville, MD 20782 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. Barbour Cemetery 03-03-2008 Nathalie, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, NW Washington, DC 11/2 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shifts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscherotic Covenory Liseese **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 1 Yes 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 XYes 2 □ No Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Inpatient 2 XER/Outpatient 3 DOA this After thi Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 52326 2008 271 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James K. Lightfoot, Jr. 7600 Carroll Avenue Takoma Park, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 5 2008 Registrar

08-01637 Thomas Bragg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

homas E	Bragg		Sta 1- For State Registrar	ate of Maryland		artment of rtificate of		and	Menta	al Hyg		eg. No.	200	8	0858
Pl Medical	hysici Exami		1. Decedent's Name (First, Middle Thomas	e,Last) Bragg							Date of Dear Month February 2	Day	Year		ne of Death 25 hrs
			4a. Facility Name (if not institution			4	b. City, Tow	n, or Lo	cation of		Coloary	4c. Cou	nty of Deat		
			Southern Maryland Ho				Clinton						e Georg		
	neral ector			6. Sex 7. Aga Male 2 F 68		ast birthday) Yrs.	If Under 1 Months	Year Days	If Under:			01,193			(State or DC
	пу		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Location	on							10d.	nside City Limits
Pu	28a-f show any d at once.	r	Md Princ	e George	Fo	restvi	lle							1 X	Yes 2 No
Maryla	28a-f dator	Director	10e. Street and Number				10f. Zip Co				1	0g. Citizen o	f What Cou	intry?	
th the	or items 23a or 28a-f sho must be notified at once	I Di	5511 Marlbor				2074					JSA			
sath wi	items ast be	Funeral	11. Marital Status 1 Never Married 2 X Ma	12. Was Decedent Armed Forces?			s Decedent e es, specify C				ify Yes or No can, etc.)		Race - Ame Vhite, etc.	rican In	dian, Black,
after de			3 Widowed 4 Dive	or Dates:	X No	1	Yes 2 X	No s	specify:			Spec	afy: Bl	ack	
hours	natur	ed b	15. Decedent's Education (Spec	cify only highest grade com		16a. Decedent during mo	's Usual Oc ost of workin					16b. Kind o	of Business	/Industr	у
215-0036 be filed within 72 hours after death with the Maryland	ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	Completed by	Elementary/Secondary (0-12) 12th	College (1-4 or 8	5+)	Truck		_				Priv	ate	Ind	ustry
21215-0036 and be filed within 7	Mental Hygiene. marked other than c event, the Medical		17. Father's Name (First, Middle,	•		<u> </u>						Maiden Surna	ame)		
121 Id be fi	dental narked event,	o Be	Lorenzo Br 19a. Informant's Name/Relationsh	agg	- 1	10h Mailing	Address (lli.		Barbe:	nber, City or	Town Stat	o Zin C	ada)
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the Hosp	within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exar and manner stated.											e(s)
و ا	¥ £ 8	Me	29b. Signature and title of certifier	12.4				icense r					signed (M		ay, Year)
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01	0)		 Name and address of person Donna M. Vincenti, MI 			,	Penn St	reet, E	Baltimor	re, MD	21201				
	St Regis	ate	31. Date filed (Month, Day, Year) MAR 0 5 2008	32. Registra							-				

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			Laurel Regional Hospi	ital		Laure1			Prince	George's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birtho Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v. Year)	Birthplace (State or Foreign Country)
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	items	Funeral	11. Marital Status 12. Was Arme 1 □ Never Married 2 □ Married 1 □ N	Decedent Ever in U.S ed Forces? Yes 2 X No	S.	 Was Decedent of His If Yes, specify Cuba 	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - A Black, W	umerican Indian, Vhite, etc.
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and	be fil ntal H ed oth even	Be	17. Father's Name (<i>First, Middle, Last</i>) William A. Armwood						, Maiden Surname)	
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Z Z	nd 2 s lith an 27 is rtrau		Emma C. Armwood/Siste		l	6 Quackenbo			ashington,	
ก	s 1 al	18	20a. Method of Disposition	20b. Pl		Disposition (Name of crematory or other place		Date	20c. Location - City	
Daillinor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 □ Cremation 3 □ Removal f 4 □ Donation 5 □ Other (<i>Specify</i>)	TOTTI State		coln Cemete	1	-2008	Brentwood	, MD
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only 1 ► ertifying Physician: T 2 ☐ Medical Examiner: On the							
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	5 ½ C 8		29b. Signature and title of certifier			29c. License	00 f U 5	-2G	29d. Date signed (M	onth, Day, Year)
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	Funeral Director		5. Social Security Number 6. S	i M 2⊠F	ge (In yrs. lasi	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day,	Year)	Coul	, ,	
ŀ			220-26-2526 Usual Residence of Decedent		76					/23/19	32	Edmor	nston,	_MD
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Dallimor	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Foneral Service Licer	isee	n		. Name and Addres		•		473	9 Balti	more A	venue
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`	with com	×	29b. Signature and title of certifier	2			29c. License	e number	3850) 2	9d. Date	signed (Month,	Day, Year)	
L	(5)		30. Name and address of person who have a company of the state of the	alli, Mi	death (Item 23 75 trar's Signature	25	Sreenwa	y Co	te.]	DR. G	ree	enbelt	MDo	20710
	Sta Registr		MAR 0 5 2008	L. J. Heyisti	k A	180	,	J				,		
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			1 - For Stata Registrar	State of N	/larylan		artmen rtificate			and M		gienë Reg. No.	08	08583
9	Physici	an	1. Decedent's Name (First, Middle,	Last)	?						2. Date of De Month	aath Day	Year	3. Time of Death
	/Medi		N/14		SAN	0					03	03	08	0531 M
	Examir	ner	4a. Facility Name (If not institution,						Location o	of Death			ity of Death	7 7
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(p.)	Funeral Director		5. Social Security Number 577–58–2898 Usual Residence of Decedent	1 M 2 F 7. A	61	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April	5,1946	9. Birthp Cour Wash	place (State or Foreign try) ington, DC
	e Maryland 8s-f show tified at	ctor	10a. State 10b. County	George's		y, Town or Lo Bowie	cation						1	0d. Inside City Limits 1 ☐ Yes 2 KNo
	th with the 23s or 2	al Dire	13423 Idlewild	Drive			10f. Zip	^{Code} 2071	5			10g. Citizen o USA	f What Cour	ntry?
9036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itema 23a or 28a-1 show other than "natural", or Itema 23a or 28a-1 show event, ire Medical Exam arminat must be notified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🕱 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 1 Yes 2 1 If Yes, Give Year or Dates	s? g tNo		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spo i, Puerto	ecify Yes or No Rican, etc.)		ace - Americ ack, White, ify: Wh	etc.
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	1 and 2 s Health ar em 27 ie ther trau		19a. Informant's Name/Relationship Bela A. Bano Sr 20a. Method of Disposition		20b. P	1342	3 Idl	ewil	d Dri	.ve,E	Bowie M	D 20715		
Baltimore,	Page nent o ant: if ury or		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)		lace of Dispo emetery, crer Vet. Cei	meter	У		larch 200	8	Crowns	ville	
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	Physician /Medical Examiner		23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	dely	Mexa	S tax	or dying	Ca		greav			Approximate Interval Between Onset and Death J LAN
8760,	sate be executed obysician and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a										
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Ĕ	sicien: certific irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				A Othe	r.		(Check only o			
Division of Vital	D 00 C	!-	27. Manner of Death 1	28a. Date of In (Month, D	jury	ER/Outpation 28b. Time of Injury		Bc. Injury Work	4 🔲 1401			dence 6 🗆 O		ý)
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	one)	Physician: To the bes aminer: On the basis and manners	of examinat	wledge, death ion and/or inv	estigation,	in my op	inion, deat	d place, h occurr	and due to the ed at the time,	date and place	, and due to	the cause(s)
)	S To With	Σ	29b. Signature and title of certifier that	12	ent	d m	1	License		143	8	29d. Date sign		
	De		30. Name and address of person what have a second s	A ENA	death (Item	44	Privat)	EYE	USE	His	HWAY	ANNI	POLS	3,2008 MD21401
	Sta Registr		MAR 0 5 2008	See 32. Hegis	ii ai s Signat	16								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ben NMN Betis 5 March 2008 4:57 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Williamsport
If Under 1 Year If Under 24 Hrs. Williamsport Nursing Home Washington County 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 F Hours 112-32-1296 Director 87 Dec 2,1920 Philippines Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location marked other than "natural", or Items 23a or 28a-f show matic avent, the Madical Examinar must be notified at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 ☐XNo Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 242 Sunbrook Lane 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Deceder 2: 100 1 Yes, Give 1946— Year or Dates: 1970 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Government permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic avent, since. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Felipe Betis Petra Domingo Betis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian M. Betis-wife 242 Sunbrook Lane Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5-13-2008 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cemetery Arlington, Virginia 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, AD 21742 21. Signature of Funeral Service Licensee Kaitlin 23a. Part1. Enter the disease, are implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia Sweeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Uncertain Etiologi 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 1□ Yes 2□No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 wursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation I Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral (1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) morea Kuterer-Sand, no D47451 March 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nursing Home, 15+ North Artizan Street
Cynthia Kuther. Sands mp Williamsport Nursing Williamsport, Maryland 217 5H-15+1 Williamsport, Maryland 21795 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar MAR 0 6 2008

			1 - For State Registrar	State of Maryla		artmen rtificat			and Me		jiene eg. No.	008	035	385
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	/Medic Examir		4a. Facility Name (If not institution, give si SunBridge Care & R		n Ctr	4b. City,	Town, or	Location o	of Death			nty of Death		
* 3	Funeral Director	-	5. Social Security Number 6. Sex		i. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day March 26	Year)	9. Birthp	lace (State of htry) arylar	or Foreign
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980	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or lieme 23a or 28e-f show aumatic event, the Medical Exemiting rough by notilitied at	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 XWidowed 4 Divorced	 Was Decedent Ever in l Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 		Was Dece If Yes, spe 1 ☐ Yes			gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)	14. F Spe	Race - Americ Black, White, cify: W		
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Balti	permit. Pages Department of Importent: If I sny Injury or once.		21. Signature of Funeral Service License	PROFESSION (C L	Name ar	Addres	s of Facility terso: Mar	n & S	on Fun 21903	eral H	Iome, I	P.A.	-
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lon of	iing Ph n. After th funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work		28	8d. Describe h			· <u>·</u>	
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			Paul A. Gian	akon, m.o	_ 32		Tjen	OR.	Ho	CKEJJ	iù	DE	197	07
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			1 - State Registrar		•	Cei	rtificate of	Death	,	Reg. No.		
	TELL E	41	Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death
	Physici /Medic		Frank	D. Boy	er	Jr.			Month March	Day 2	2008	_ 10:18 Å
	Examin		4a. Facility Name (If not institution,			-	4b. City, Town, o	r Location of Deat		4c. C	ounty of Death	20120 22
			Kline Hospice	House			Mt.	Airy			Frede	rick
902. Pt.	Funeral Director		220-52-1920	6. Sex 7. Ag 1 M 2 ☐ F	e (In yrs. I 57	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	th 12, Year) 12,19	9. Birthp Coun Mar	lace (State or Foreign try) yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation				1	0d. Inside City Limits
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	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Coun	try?
	th with		2504 Hemingwa	y Drive, Uni	ite T	C.	21702			Unite	d State	S
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 Tyes 2 XI If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🂢 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		I. Race - America Black, White, of Specify: Whi	etc.
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and	id be fi ental H ked otl	To Be	17. Father's Name (First, Middle, L Frank D. Boyer	ŕ					^{ne (First, Middle} rine Ear		urname)	
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ē,	s 1 ar f Hea item other	1 2	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other place	201	Date	20c. Loca	ation - City or To	wn, State
Ë	Page nent o nt: If		1 ∑ urial 2 □ Cremation 4 □ Donation 5 □ Other (<i>Sp</i>		1		en Memori		2008	Fred	lerick,	Maryland
Baltimore,	permit. Departmine importa any injuite. once.		21. Signature of Funeral Service L	censee	7	22	2. Name and Addre	ss of Facility S				
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	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):						
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٦,	res that the de signed by the a be detached t		Part II. Other significant condition	s contributing to death be	ut not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to th	ne cause of death?
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)	To th within To th	Me	29b. Signature and title of certifier	Comer,	UN.		29c. Licens	e number		29d. Date.	signed (Month,	Day, Year)
	V		30. Name and address of person w	ho completed cause of d	eath (Item	23a) (Type,	Print) EVENTH	-ST. F	REPERI	CK,	no z	1701

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 2:30A M 2008 Garnett M. Bell 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Plata Medica harle IVISTA enter If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1 M 2 F Months Days 218-20-2167 85 July 19,1922 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11960 Lincoln Drive 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 📉 No Specify 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Pratt Bertha Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry A. Bell 11960 Lincoln Drive, LaPlata, Md. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 4, Metropolitan Funeral Service 2008 Alexandria, Virginia 21. Signature of Funeral Service L Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian Head, Md. 20640 M00668 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THERUS CLERRIST DUGINCIED Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ONGVESTEVE Due to (or as a consequence of)

Physician /Medical Examiner

per it. Pages 1 and 2 s De, artment of Health an Important: If Item 27 is any injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

or items 23a or

Baltimore, Maryland 2121

Pages 1 and 2 should be

the Medical Examiner must be

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

the death certificate be executed the burial attending p nse signed by the aid be detached f

page 2; has this After thi funeral within 24 hours after death.

To the Funeral Director: Aft

completely filled in by the fur

Division or Vital Records, P.O. Box 68760.

M						
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year
þ	Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.		co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Completed			-		24a. Was an autopsy pertormed	
Be (25. Was case referred to medical examiner?			26. Place of D	eath Check onl one	
To	1 Yes 2 XNo	Hospital: 1 Inpatient 2	□ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)
	27. Manner of Death 1' Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	
Certification:	3 Suicide 6 Could not l 4 Homicide determined		nome, farm, street, fact	tory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Medical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of my knaminer: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
×	29b. Signature and title of certifier		1	29c. License number	29d. I	Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Pembrooke Square Suite 103 Waldorf, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

H. WathenMD 11345

2008

31. Date filed (Month, Day, Year)

MAR 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 March 3. 7:16 P M Martha Ingraham Bennett 4c. County of Death 4b. City. Town, or Location of Death

Physician /Medical Examiner

Funeral Director

ral", or items 23a or 28a-f show Examiner must be notified at 'natural", or

filed within 72 hours after death with the Maryland n and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othn any Injury or other traumatic event once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and attending physician the th ed by the detached has after death Director:

The law requires that the death certificate be executed

Hospital or Attending Physician:

e Funeral L

the To the within ? completely

Division or Vital Records, P.O. Box 68760,

þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Doctor 17. Father's Name (First, Middle, Last) Be Jeanette MacDonald William Blodgett Bennett 19a. Informant's Name/Relationship (Type. Print) K. Francois Bikamba/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 03/05/08 21. Signature of Funeral Service License Mo MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bruzin TUMOR Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☑No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes Completed 24a Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ∏ Yes 2 ∏ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 040/33 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4a. Facility Name (If not institution, give street and number) 1712 Overlook Drive Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🛣 □ F 125-58-9212 46 Nov 27, 1961 New York Usual Residence of Decedent 10b, County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MDSilver Spring Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20903 USA 1712 Overlook Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 16b. Kind of Business/Industry Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1712 Overlook Drive Silver Spring, MD 20903 20c. Location - City or Town, State Beltsville, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 3 YGARS - ANAPUTSTIC ASTROC 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 10810 CONNECTICUTAVE, KENSINGTON, MIK DUTKA MA KAISER KENSINGTON

State Registrar

31. Date filed (Month, Day, Year)

MAR 05

2008

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** ALVIN 2008 1525 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Jan 17, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** ÃΑ 85 Director 218-12-5906 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Wiley Ford WV Mineral 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be n 26767 USA General Delivery Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify Specify: Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PPG Industries** 12 Quality Control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finand Mental F : 1 and 2 should b Health and Menta tem 27 is marked James Quinter Bennett Toleda Northcraft Bennett 77 is marked traumatic of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HC 64 Rox 3630 Romney WV 26757 19a. Informant's Name/Relationship (Type. Print) James Bennett son : If item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 Burial 2 Cremation 3 Removal from State Abe Cemetery 3/15/2008 WV Important: I any injury o Short Gap 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a construence of): mont /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sela conegguanda offi Examiner death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1□ Yes 2☑No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D002337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 SETON DRIVE Cumberland, MD 21502 DR Qamar Zamow 31. Date filed (Month, Day, Year) 32, Registrar's Signature State MAR 18 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** William Preston Boyd 26 2008 /Medical February 10:00 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-Memorial Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Davs Months Hours 1 X M 2 □ F 218-60-0299 Yrs Director 56 Maryland 04/02/1951 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at Director MD Allegany Cumberland 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11314 Ore Street, NE 21502 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status o filed within 72 hours after dan Hygiene.

Other than "natural", or item Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 X Never Married 2 ☐ Married 1971 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 Widowed 4 Divorced 1973 White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th 12 Laborer Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Franklin Boyd Lela Pearl Minnick ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a Important: If item 27 is any injury or other trau Sara Gernat / Sister 11305 Ore Street, NE., Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State MD Vet Cem @ Rocky Gap 02/29/2008 4 Donation 5 Other (Specify) Flintstone, MD 21. Sign fur, of Funeral Service Li 22. Name and Address of Facility Adams Family Funeral Home, any in 404 Decatur Street, Cumberland, MD 21502 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed labetes sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending plant for use as IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation ithin 24 hours after death.

o the Funeral Director: A
ompletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely To the I within 2 and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0040095 February 27, 2008 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Pelligrino, M.D., 200 Glenn Street, Cumberland, MD 21502 n ds 31. Date filed (Month, Day, Year) FEB 2 8 32. egistrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CARL 02 BAKER 24 2008 /Medical 1410 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 90 217-18-4849 Maryland September 24, 1917 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Show r 28a-f sh notified 1 ☐ Yes 2 No Director Maryland Garrett Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2623 Finzel Road ortant: If Item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be a 21532-Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates; 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>}</u> Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer 12 should be filed w h and Mental Hygier 7 is marked other th self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Velma Wagner ပ Edward Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is:
any injury or other tree... daughter 21532-Doris Rosenberger Frostburg Maryland 2616 Finzel Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) February 27, 2008 Emmanuel Methodist Cemetery Finzel Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATTC LIVER CANCINO **Physician** 15A12 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 DISTA KIDNEY 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate ! 2 **1** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3□ DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation Injury ithin 24 hours after death.

to the Funeral Director: A

ompletely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

MAS State

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29b. Signature and title of

30. Name and address of pers

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31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

YSI CIAN

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

LOVERIA JR.

29c. License number 950844

29d. Date signed (Month, Day, Year)

912 STON PRIVE CUMBURGANDMD21502

			7 - State Registrar			Cei	rtificate of	Death		Reg	. No. 🚄 👢	JUU	00094
П	J = 1	RD	1. Decedent's Name (First, Midd	tle, Last)					2. Date Mor	e of Death	Day	Vaar	3. Time of Death
•	Physici /Medic		СН	IARLES DENI	NIS	BROWN	1		FEI		26, 2	Year 1008	12:55 P ^M
1	Examir		4a. Facility Name (If not institution	on, give street and number)			4b. City, Town, o	r Location of De	ath		4c. County	of Death	
			346 NORTH SU	MMIT AVE. #00	02		GAI	THERSBU	RG		MON	TGOME	ERY
	Funeral		5. Social Security Number		e (In yrs. la	as <i>t birthd</i> ay)	If Under 1 Year Months Days	If Under 24 H		e of Birth onth, Day, Y	(ear)	9. Birthp	nlace (State or Foreign
8	Director		220-54-6460	1 X M 2□ F	57	Yrs.	World Days	Tiours IVI			,1950		YLAND
	P.		Usual Residence of Decedent		1								
	irylar show	_	10a. State 10b. County	У	10c. City,	, Town or Lo	cation					1	0d. Inside City Limits
	e Ma la-f s tiffied	cto	MD. MONT	GOMERY		GAI	THERBURG					İ	1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of \	What Cour	ntry?
	th wi		346 NORTH S	SUMMIT AVE. #	002		20	877			υ.	S.A.	
	ems er m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13. \	Was Decedent of H	lispanic Origin? an. Mexican. Pu	(Specify Ye	s or No-		e - Americ	
9	afte or it		1 ☐ Never Married 2 ☐ Mar	rried 1 Yes 2 X	Vo		1 □ Yes 2 👿 No	Specify:	,	,	Specify		Cito.
ğ	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	d by	3 ☐ Widowed 4 X Divorced	d Year or Dates:							- Opecing	WHI	TE
2-0036	hin 72 hours after death with the Marylar e. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	Completed	15. Deceder (Specify only highe	ent's Education est grade completed)		(Give	dent's Usual Occup kind of work done	during most of v	vorking	16	b. Kind of B	usiness/ind	dustry
7	iE ≪ E SE	ld II	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. I	DO NOT use retired	d)					
7	filed w Hygier other th			4			OWNER					s co.	
Maryland	be filed wit ital Hygiene d other that event, the	Be	17. Father's Name (First, Middle,	, Last)				18. Mother's N	lame (First,	Middle, Ma	iden Surnan	ne)	
<u>X</u>		မ	CARLTON	A. BROY	ΝN				LORIA	т.		RDEST	
ā	C1 00 100 100		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route	Number, C	City or Town,	State, Zip	Code)
	and ealth n 27 rer tr			RMON/EXWIFE				COMMON					MD. 21666
Baltimore,	ges 1 t of H If iter or oth		20a. Method of Disposition 1 Burial 2 Cremation	3 DRemoval from State	20b. Pta	ace of Dispo emetery, crer	sition (Name of natory or other plac	ce)	Date	20	c. Location -	City or To	own, State
Ē	Pa ant: ury		4 Donation 5 Other (СН	AMBERS	CREMATO	RY 3-	3-2008	3 E	RIVERD	ALE,	MD.
a	permit. Departr Importa any Inj		21. Signature of Funeral Service	e Licensee	5)	22	2. Name and Addre	ss of Facility	HOME				
n	80 E # 9		W.M. C	namercial	M00	091 5	801 CLEV	ELAND A	VE., E	RIVERI	DALE,	MD. 2	20737
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that caused st only one cause on each lin	the death.	Do not ent	er the mode of dyir	ng, such as card	iac or respir	atory arrest	t,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	STROKE									Onset and Death
>	/Medical		resulting in death)	Due to (or as	a consequ	ence of):							
	Examiner			b. CORONARY	7 ART	ERY DI	SEASE						
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as									
	cuted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	DIABETES	5								
ń	exection and and rial-tr	Ex	resulting in death) Last	Due to (or as	a conseque	ence of):							
08/00	certificate be executed rding physician and ise as the burial-transit	ca		d									
õ	tifica ig ph as th	/Medical											
ŏ	h cer andin use	<u></u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75-4				23d. Da	te of delive	ery
ň	deatl	Physicia	in the past 12 months? 1 □ Yes 2 □ No	1∐Live birth 4∐Pregnant at			Ectopic pregnancy Other (specify)	/			Mo	onth	Day Year
9	t the by the ache	hys	9 □ Unknown	9□Unknown									
S,	s that ned b	by P	Part II. Other significant conditi	ions contributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.	230	e. Did toba	cco use cont	tribute to th	ne cause of death?
ğ	quire; n sig								_	1 ☐ Yes	2□ No	3 ☐ Prob	ably 4 Unknown
ecord	w red	Completed							248	a. Was an	24b.	Were auto	psy findings available
ı L	he la has ige 2	g E							-	autopsy performe	d?	prior to co death?	mpletion of cause of
VITAI	n: T ficat or, pa		25. Was case referred to medica	al				00 01 6			No	1 ∐ Yes	2□ No
>	sicia certi recto	Be (examiner?	Hospital:	nt 200	D/Outpation	t 3 DOA Oth	26. Place of E					
0	Phy r this ral di	: To	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of Inju		28b. Time of	I JL DOA	4 ☐ Nursing			ce 6 Oth		y)
	ding h. Afte fune	tion	1 Natural 5 ☐ Pendii		y Year)	Injury	Wor	k? Yes 2 ∐No			mjary coca.		
VISION	deat deat ctor: y the	ica	3 Suicide 6 Could	not be	urv - At hor	ne. farm. str	eet, factory, office		28f Loc	ation (Stree	et and Numh	ner or Rum	I Route Number,
<u> </u>	or A after Dire	Certification:	4 ☐ Homicide determ	mined building, etc	c. (Specify))	, , ,		City	or Town, S	State)	,0, 0, ,111,0	Troute runner,
	spita ours neral filled		29a. Certifier 1 Xcertifyi	ing Physician: To the best	of my know	/ledge, death	n occurred at the til	me, date and nis	ace, and due	to the cau	se(s) and m	anner as s	tated.
	24 h	edical	(Check only 2 Medical one)	I Examiner: On the basis of and manner sta	f examinati	on and/or in	vestigation, in my o	pinion, death of	ccurred at th	e time, date	e and place,	and due to	the cause(s)
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Laneral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Med	29b. Signature and title of certific	•			29c. Licens	e number		29d	. Date signe	d (Month,	Day, Year)
1	1/50		1	//				050701				•	000
	1		30. Name and address of person	n who completed cause of d	eath (Item	23a) (Time		059794			MARCH	3, 2	008
				·					l Boo	יידעעי	D 340	200	E.A.
	Sta	to.	31. Date filed (Month, Day, Year,	r) 32, 201	ar's Signati	IN LOC	KS RD. SI	OLIE II.	L, KUC	KVLLL	r, MI)	. 208	J4
0	Registr		MAR 0	4 2008	10 1	or A	next!						

10b. County

4807 Bayard Boulevard

1 Never Married 2 Married

₩ Widowed 4 Divorced

_ For	State c	or Maryland / Depa	artment of Health and I	Mental Hygi	ene		
For State Registrar		Cei	rtificate of Death	Re	g. No. 🤈 ု	108	0950
1. Decedent's Name (First, Midd	lle, Last)			2. Date of Death	6- 1	100	3. Time of Death
Agnes	Nunn	Bower		Month February	28, 2	Year 2008	1:40 p M
4a. Facility Name (If not institution	on, give street and nu	imber)	4b. City, Town, or Location of Death		4c. County	y of Death	
Rockville Nur	sing Home		Rockville		M	lontgo	mery
5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign
195-28-2352	I UI VI ZLA	95 Yrs.		Jan. 3,	1913	Iowa	**
Usual Residence of Decedent		•					

Bethesda

20816

10f. Zip Code

1 ☐ Yes 2 ☑ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian,

Medical

Spring, MD 20901 Approximate Interval Between Onset and Death

Week

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Black, White, etc.

Specify: White

23d. Date of delivery

Month

USA

1 TYes 2 TNo

10c. City, Town or Location

Montgomery

12. Was Decedent Ever in U.S. Armed Forces?

Funeral Director

Director

Funera

2

10a. State

Maryland

11. Marital Status

10e. Street and Number

/Medical Examiner

death with the Maryland r 28a-f shov notified at "natural", or items 23a or edical Examiner must be permit. Pages 1
Department of H
Important: If Ite
any injury or ot

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

be executed sician and burial-trans as the attending p cate has been signed page 2 should be deor Attending J Director: / To the Hospital or within 24 hours af To the Funeral D

Division or Vital Records, P.O. Box 68760.

1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychological Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bentley Nunn 2 Anna Agnes Noonan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen B. Kerr/Daughter 4807 Bayard Boulevard, Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State March 4, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2008 21. Signature of Funeral Service Licens 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spri 23a. Part1. Enter the disease, or o impli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on k on cause on each line. Immediate Cause (Final disease or condition resulting in death) Urinary Tract Infection Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced Dementia 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Cutpatient 3 DCA 1 ☐ Yes 2 No Other: 4 🛮 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1XXNatural 5 | Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🏞 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53367 March 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Shyamsundar Rajan, MD

MAR 0 4 2008

31. Date filed (Month, Day, Year,

State Registrar 9801 Georgia Avenue, #112, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per verb., 88/7,03/21/08dhb
Reg. No.
Reg. No. 1 - For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3:05A M March 2, 2008 Far Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomic Salisbury Rehab & Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (IM)rs. last bit alisburu If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min 1**⊠**M 2□F 55 243-92-1619 Usual Residence of Decedent 13 53 Director permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or themed other traumatic event themed once. 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 1 Dres 2 No **Funeral Director** Wicomico W YL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2180 Branc rang 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Completed by 3 ☐ Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ITI WEY 1a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 19a. Informant's Name/Relationship (Type. Print) Rd Office Princoss Anne Blown 20723 Momas 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1-N Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) cometer St 22. Name and Address Fsabell9 W. 21. Signature Salis bury Mb 218 Bennie Smith Funeral Home 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death sophaseal Immediate Cause (Final disease or condition resulting in death) tasto Kall **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown s been signed by t 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Munknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy has The 21 this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only only) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1.2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name no completed cause of death (Item 23a) (Type, Print) 21853 304343 Mt. Vernonika. Princess Anne, MD mann W.D. 32. Régistrar's Signature State 2008 Registrar

			State of Maryland / De State of Maryland / De	epartment Certificate				iene	08	08595
	Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Dav	Year	3. Time of Death
	/Medi	cal	Winfred Vernard Cain 4a. Facility Name (If not institution, give street and number)	4b. City To	own orloca	ation of Death	March	2, 200		0424 M
	Exami	ier	Harford Memorial Hospital			de Grac	e		arfo	rd
	Funeral Director		5. Social Security Number 213-66-7868 6. Sex 12□ M 2□ F 7. Age (In yrs. last bintho	Months		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Sept. 29	, 1956	Cour	place (State or Foreign ntry) aryland
	land w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location					1	10d. Inside City Limits
	Mary a-f eh	tor	Maryland Cecil	Perry	ville					1⊠Yes 2□No
	if the or 284	Oirec	10e. Street and Number	10f. Zip C	Code		1	0g. Citizen of W	/hat Cour	ntry?
	eth w	rai	534 Broad Street, Apt. No. 4		21903				.S.A	
75	ite; Mal yial to Z LZ I 3-0030 s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23e or 28e-1 ehow other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 🗷 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates:	13. Was Deceder If Yes, specify 1 ☐ Yes 25	y Cuban, Me	ic Origin? (Spe exican, Puerto ecify:	ecify Yes or No- Rican, etc.)		k, White,	can Indian, etc. :lack
7	72 hou	ted	15. Decedent's Education 16a. De	ecedent's Usual Give kind of work		most of worki		16b. Kind of Bu		
2/08 042	hen r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use	retired)	j most of worki		-	-	Company
7	filed v Hygie ther ti	CO	Twelve Years 17. Father's Name (First, Middle, Last)	Weld		Mother's Name	(First, Middle, I			t,Maryland
50	y large	To Be	Herbert Isaiah Cain				nor Ann			
7	Carylation & L& 1& 1& 1& 1& 1& 1& 1& 1& 1& 1& 1& 1& 1&			Mailing Address (
U	os 1 and 2 of Health item 27 i			O. Box 6			The second second	yland 2. 20c. Location - 0		
03/0	Dartillor permit. Pages 1 Department of F Important: if ite any injury or ot once.		1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferr	ris & Co.	, Inc.	03/04	4/08 W	lest Chest	er, E	Pennsylvania
	Departimon to the policy of th		Will was it - Teleterson V	Lee A. F Perryvil	le, M	aryland	219030	- 766	e, P	
			23a. Part I. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final		of dying, suc	ch as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease of condition resulting in death) Due to (or as a consequence of the condition of t	y Fai	lure					
rgu	Examiner		Anna E.	ncepha	alopa	thy				3 days
′	be sit	iner	Suggestially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury) Dighetic	:			,			/
	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):	Coma	ch	y post	cemia		-	
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4	entifica ling ph	Med	IF FEMALE:						-	
red	be the best	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic preg 5 ☐ Other (spec				23d. Date Mon		ery Day Year
7	es thet the igned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	ne undertying cau	use given in l	Part I.	23e. Did tob	pacco use contri	ibute to t	he cause of death?
	v require been sig	ted	morbid obesity				1 □ Ye	s 20XNo	3 Prot	oably 4 □Unknown
ain, Win		Completed	Sleep apnea				24a. Was al autops perform 1 Yes 2	y pi ned? di	rior to co eath?	opsy findings available impletion of cause of
	vicien: The certificete rector, pag	Be	25. Was case referred to medical examiner? Hospital:		Othor		(Check only on			
20	Phys or this	. To	27. Manner of Death 28a. Date of Injury 28b. Tim		Other: 4		me 5 Reside			(y)
	Attending Physicien: r death. ector: After this certific by the funeral director,	ation	15⊘Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation 03/02/2008	M M	Work? 1 ☐ Yes					
Contraction	al or Atte s after de il Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, o	office		28f. Location (St City or Town	reet and Numbe n, State)	er or Rura	al Route Number,
#33 #	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	leath occurred at or investigation, in	the time, da	ate and place, and death occurre	and due to the ca	ause(s) and mar ate and place, a	nner as s and due to	stated. o the cause(s)
11, 10	To the To the Comp	×	29b. Signature and title of certifier	29c. I	License num	nber	2	9d. Date signed	(Month,	Day, Year)
	~~~		30. Name and address of person who completed cause of peath (Item 23a) (Ty	M// D	421	07	A	0/2/	0 8	)
	5	· a	John Burthorne Sumpson, 1  31. Date filed (Month, Day, Year)  32. Register's Signature	1p 50	015.	UNION	V Ave	HAURE	de G	RACE MD.
- 1	Sta Registi		MAR 0 5 2008 Keeper & A	book						

Funer: Directo

	Registrar     Decedent's Name (First, Mid	idle, Last)	<del>-</del>	Cei	rtilicate	of L	Death		2. Date o		. No	008	3. Time of I	Death
an al	JERALDINE AN	NE CONNOR							FEBR	JARY		2008	1:30	F
er	4a. Facility Name (If not institute  80 ALGONQUIN  5. Social Security Number		mber) 7. Age (In yrs. I	(aad birdhalaa)	4b. City, 1	RTH	EAST  If Under		8. Date o	Dia		ectL	(2)	
	214-82-5782 Usual Residence of Decedent	1 ☐ M 2 <b>X</b> F	56	Yrs.		Days	Hours	Min.	APRII	Day, Y	ear) 1951	Cou	place (State or ntry) MARYLA	
Director	10a. State 10b. Coun	CCIL		y, Town or Lo		Code				100	. Citizen o	of What Cou	10d. Inside Cit	
Funeral Di	80 ALGONQUIN	12, Was Dec	edent Ever in U.	S. 13. \	Was Deced	21	.901 ispanic Or	igin? (Sp	ecify Yes o			USA lace - Ameri		
by	1 X Never Married 2  Ma 3  Widowed 4  Divorce	If Yes. Gi	2 <b>X</b> No		lf Yes, spec 1 ⊡ Yes 2 dent's Usua	X No	Specify.		Rican, etc.		Spe	lack, White,  cify:  WI  Business/Ir	HITE	
Completed	(Specify only high Elementary/Secondary (0-12)	hest grade completed) College ( -0-	1-4or 5+)	(Give life. L	kind of work DO NOT use DISABI	k done a e retired,	during mos				DI	SABLE	•	
To Be	17. Father's Name (First, Middl WILLIAM J.	CONNOR					I	RMA 1	e (First, Mic	ΓY		•		
	19a. Informant's Name/Relation	1 1 77		900 PC	ORT ST	ſ.,		4108	B, EAS	TON	, MD	· · · · · · · · · · · · · · · · · · ·		
	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	Ctota	lace of Dispo emetery, cren PETER	natory or ot S CE	her place METE	RY	MAR.	Date 4 , 200	3 Q	UEEN:	n - City or T STOWN ,	MD	
	21. Signature of Funeral Service	Hellent	lu	40	8 S.	LIBE	RTY	ST	CENT	REVI	LLE,	RAL HO MD 21	ME, P	Α.
	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	_aC	each line.	1. Do not ent	er the mode	of dying	g, such as	cardiac	or respirato	ry arres			Approximate Interval Betw Onset and D	/eei
		Due to	(or as a consequ	uence of):	~ \\	6	M C	$\sim$ 1	T	2/		6	475	<u>)</u>
cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. House to	(or as a consequ (or at a consequ (or as a consequ	uence of):	NG	~i	a	~1	T	٧١)		(,e	471	ار
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Place build  ying Physician: To the band man	(or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the cons	uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence	other (spenderlying cannot be seen, factory, the occurred a vestigation,	A Other Sc. 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Place Pr: 4 \( \text{Ni} \) V at Yes 2 \( \text{Triple} \)	e of Deat ursing Ho	24a. \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Vas an utopsy erformes 34 mily one)  Vasidence ibe how on (Street Town, 1 the caume, date	23d. I	Date of delive Month on tribute to the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state	the cause of debably 4 \( \subseteq \text{U} \)  possy findings a possy findings a 2 \( \subseteq \text{Normal Normal Pouts Number 1.0} \)  al Route Number 1.0 \( \text{Vext} \)  but the cause(s)	nkn nvail use

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MARCH 2008 Carl Wayne Clark /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES MEDICAL ENTER PLATA IVISTA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Min. 50 Director February24,1958 Washington D.C 216**-**76-6198 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Directo Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11785 Maryland Point Road 20662 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No 1 ☐ Never Married 2X Married 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Groundsman 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Coyal Andrew Clark Alice Mae Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Clark/Wife 11785 Maryland Point Road Nanjemoy, Maryland 20662 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Memorial
Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 ☐ Other (Specify) March 7, 2008 Waldorf, Maryland 22. Name and Address of Facility Arehart-Echols Funeral Home 21. Signature of Funeral Service Licensee M01458 211 St. Mary's Ave. La Plata, Maryland 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) OROnAR /Medical Due to (or as a consequence Examiner Sequentially list conditions, and good of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2/2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3DOA Certification: To 1 Yes 2 No 2 ER/Outpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 24 hours after death.

Funeral Director: A letely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Understand Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mather stated. 29a. Certifier Medical (Check only 24 one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN SMITHMOST GARRETT AVE Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM 5 10e per INF. C877 3/31/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 3, 2008 **Physician** 11:05 PM Mary Lee Chatrnuck /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 5. Social Security If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 13, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year 1926 West Virginia Months Days Hours 1 M 2 X F Dec. 725-01-081 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show ä a or 28a-f sho be notified a 1 ☐ Yes 2X No Director MD Prince George's Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 **TISA** 3152 Gracefield Road e filed within 72 hours after death wi al Hygiene. I other than "natural", or Items 23a vent, the Medical Examiner must b "natural", or Items 23a odical Examiner must b Apt.108 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1∐Yes 2∐XNo 3altimore, Maryland 21215-0036 Specify: Specify: White ģ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Georgia Elsie Poling Fredrick Earl O'Neal ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 9200 Pleasant Court Laurel, MD 20708 James L. Patton/executor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 03/05/08 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a co sequence of): Physician resulting in death) /Medical Examiner Due to (or as a colse juence (f) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No for Month Day 5 ☐ Other (specify) ed by the a detached for 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 🖭 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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DHMH 17 Rev 1/2001

State Registrar

Lincoln MAR 0 5 31. Date filed (Month. 2008

29b. Signature and title of certified

1400 Forest 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

# 200

29d. Date signed (Month, Day, Year)

Silver Spry MD 20910

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day **Physician** A M 3-6-2008 2:20 Mary Elizabeth Crone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Vindobona Nursing Home Braddock Hts. Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Yrs. 219-20-2879 96 10-11-1911 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event the New Years. 10a. State 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 No Director Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5327 Ivy Wood Dr. North 21703 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeping Masters Motel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Haupt Vandelia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Griffith Grndsn 12011 S. Scotish Ct Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-8-2008 | Middletown, MD 4 ☐ Donation 5 ☐ Other (Specify) Middle Ref. Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford P.A.F.H. Mar M01176 106 East Church St Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCHRDIAL INFARCTION MINUTES /Medical Due to (or as a consequence of): Examiner TEARS MRTERY DITENTE CORONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe HEMENTA 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 1□ Yes Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes death. 2 Accident 24 hours after death Prineral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 116675 MARCH 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUN SWICK MIGHER 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 MAR 18 Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Elsie Hattie Frieda Dehne 29 February 2008 9:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare <u>Severna Park</u> Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🕱 F 212-09-9398 Director 95 Feb. 28 1913 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 ☐ Yes 2 🙀 No Director MD Anne Arundel Severna Park · 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 621 Cypress Road 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the Nonce. Clerk 12 Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Zinnert Frieda Borchert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles G. Dehne/Husband 621 Cypress Road Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 5, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4 □ Donation 5 □ Other (Specify) 2008 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line; Immediate Cause (Final disease or condition resulting in death) ebrovascu **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

in 24 hours the Funeral Dires. the 2

1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) struy Millersville, MD 1/21 31. Date filed (Month, Day, Year) MAR 0 3 2008 Registrar **ORIGINAL** 

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F ertificate of t			giene Reg. No.2	08	08601
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Ma	and 2 sealth an n 27 is		Charles E. Davi			0 Kelbaug					,
ē,	f Health item 27	1 3	20a. Method of Disposition	•	20b. Place of Disp		20)	Date	20c. Location		
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	e Man 3a-f sh tiffed	ctor	Maryland C	harles				Wald	lorf				1 ☐ Yes 2 X No
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	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Stree	et and Numi	ber or Rur	al Route Numb	er, City or	Town, State, Zi	p Code)
ב ע	1 and Health tem 27		Margie Ann Davi 20a. Method of Disposition	is/Wife	20b. P		Jniversi sition (Name of natory or other pl			Waldon Date		aryland ation - City or T	, 20602 own, State
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(	DB 10		30. Name and address of person ROSE MARY IW	UNTE, M			HARLES	ST.	LA 1	PLATA,	MO	206	16
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		1 _ State	Department of Health and M Certificate of Death	
		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death 3. Time of Death
Physic /Medi		Ruby Natalie Dobson		February 27, 2008 4:22 AM
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Fenwick Landing Assisted Living  5. Social Security Number 6. Sex 7. Age (In yrs. last b.	Waldorf  wirthday) If Under 1 Year If Under 24 Hrs.	Charles  8. Date of Birth  9. Birthplace (State or Foreign
Funeral Director		216-22-0007 1 M 2 M F 86	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 26, 1922  9. Birthplace (State or Foreign Country) Mary land
and		Usual Residence of Decedent           10a, State         10b. County         10c. City, Tow	wn or Location	10d. Inside City Limits
Maryl L-f sho fied a	to	Maryland Prince George's	Brandywine	1 ☐ Yes 2 ☐ No
th the or 28a e noti	Direc	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ath wi	la	17003 Croom Road	20613	U.S.A.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>□ Yes 2 No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
n 72 hours af "natural", or edical Exami	Completed b	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	
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be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
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Page Trent c		1 LX Burial 2 Li Cremation 3 Li Hemoval from State	i i	6/2008 Cheltenham, Maryland
permit. Pages Department of Important: If i any injury or		21. Signature of Funeral Service Licensee  Moi262	22. Name and Address of Facility Huntt Funeral Home	3035 Old Washington Road Waldorf, Maryland, 20601
Physician /Medical Examiner		23a. Part1. Enter the disease or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (final disease or condition resulting in death)  a. Due to (or as a consequence of the conditions)	e of):	or respiratory arrest, Approximate Interval Between Onset and Death
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The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
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sician: s certifical lirector, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ ★ Hospital: 1 ☐ Inpatient 2 ☐ EP/O	Other	th (Check only one)  ome 5 ☐ Residence 6 🖼 Other (Specify)
Attending Physician: r death. ector: After this certific by the funeral director,	I	27. Manner of Death 28a. Date of Injury 28b.		28d. Describe how injury occurred
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le Hospit 124 hours se Funera	Medical (	29a. Certifier (Check only one)  1 Sertifying Physician: To the best of my knowledge and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Waln I amen	232506	F55mmy 28, 2008
S 11		30. Name and address of person who completed cause of death (Item 23a)  W.11.m. T. Janne wy 1701 L	(Type, Print)  Wingston Road FT. WASH :	Atom Ilan 2074
(DD 4	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Wingston Road FT. WASHIN	11
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Nancy Lee Dugan March 02, 2008 08:35 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 35 Centennial Street Frostburg Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Min. 1 ☐ M 2 🗙 F Hours 215-26-9230 77 Director March 04, 1930 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
em 27 Is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 Centennial Street 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 21532 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mears **Emily Campbell** ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Bonnie Pressman Frostburg Maryland 21532other t 236 Talcott Avenue permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1⊠Burial 2 □Cremation 3 ☐Removal from State March 05, 2008 4 □ Donation 5 □ Other (Specify) Frostburg Memorial Park Frostburg Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility ohn Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ g 1 Tes 2 X No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only 6ne) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Tes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? 27. Manner of D ath 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tes within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) Shall M 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 425 Ker Cumberland, MD 21502 This 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 3 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February Consorcia Badilla Dawal 28, 11:23 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min. 88 564-58-8919 Director June 22, 1919 Philippines Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a State 10b. County 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 19125 Broadwater Way 20879 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Asian à 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Linen Technician Hospitals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ramon Badilla Elvilijidia Pascubillo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health as Important: If Item 27 is any Injury or other trauonce. Yetta Marie Hai (Granddaughter) 14200 Twig Road, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Catholic 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State March 8, 4 □ Donation 5 □ Other (Specify) 2008 Cemetery Colma, California 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Service 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a art1. Eller the risea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or the illure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseas or condition resulting in death) Physician Cordiac Pulmonary 10 minutes /Medical Due to (or as a consequence of): Examiner Gastric Correinoma Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician þe Physician/Medical as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No page 2 has autopsy perform certificate 2. No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director.. the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Clas D0065505 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QIUFANG HENG ROCKVILLE MD CENTER MZDICAL 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

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Registrar

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	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
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$\geq$	d Me d Me mark mati	ဥ	Charles 19a. Informant's Name/Relationsh		Garlar		a Address /Street	and Alumba	Mary or Or Rural Route Number	Elizabeth	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene.  If itam 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Madical Examinat man be nulliled at						,				,,
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ŏ	in it of or o		1 ☐ Burial 2 ☒ Cremation		ate	emetery, crei	sition (Name of natory or other place	(e)	Date	zoc. Location - City o	1 TOWII, State
ቜ	tmer tant		4 □ Donation 5 □ Other (Sp		Met	ropoli	tan Crema	atory	3/3/2008	Alexandria	a, Virginia
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 li eny injury or other tra		21. Signature of Funeral Service L	Licensee Oil	1.01	22	. Name and Addre	ss of Facilit	y DeVol Fund	eral Home	
	G □ = 9 d		vue		عكمو	X-10	East Dee	er Pai	k Dr., Gai	thersburg,	MD. 20877
			23a. Part1. Enter the disease, or on shock, or heart failure. List of								Approximate Interval Between
S. Mar.	Physician		Immediate Cause (Final disease or condition	Se	ptice	em	·				Onset and Death
	/Medical		resulting in death)	Due to O	as a conseq	uence of):	4.1		bost		
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ŏ	death certific e attending p id for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Date of de	elivery
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ō	Phys this aldii	. To	1 ☐ Yes 2 ☑ No 27. Man r of Death	1 Ung 28a. Date of		ER/Outpatien 28b. Time of	L 3 DOA	4 9/ WU	rsing Home 5 Resid		ecify)
5	ding f h. After funer	ion	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	28c. Injun Worl	k? Yes 2 □ I		now injury occurred	
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-	ours oral filled		29a. Certifier	Physician T- 4- 5	ant of multi-	wledes deed			4-4		
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	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	stated.		29c. License			29d. Date signed (Mor	
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	Sta Registr	C53	31. Date filed (Month, Day, Year) MAR 0 4 2	008	istrar's Signa	TUIN	E)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Feb. 28, 2008 Evelyn Davis 7:10p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Larkin Chase Nursing Home Bowie If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/04/1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 96 227-52-7077 Director Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 □ No Director MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 15005 Health Center Drive 20716 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Black Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Harris Catherine Cloud 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta Grant (Daughter) 5705 Justina Dr., Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☑Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Memorial Garl 03/05/2008 Norfold, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., NW, Washington DC 20011 278 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroscherotic Heart /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed the burial-transi Dementio and Due to (or as a consequence of) physician Physician/Medical IF FEMALE for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2XX to Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 2 No funeral director, Be 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

5 ☐ Pending investigation 6 Could not be determined

2 ER/Outpatient 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D20108

Other:

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 Gallant Fox Lane; Bowie, MD 20715 Rakesh Arora, M.D.

State Registra

Medical Certification: To

31. Date filed (Month, Day, Year) MAR 0 4



After this

within 24 hours after death To the Funeral Director: filled in by the

completely

Hospital or Attending

2

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Fune Direc

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	1 - State Registrar			Cei	rtificate	of De	ath		Reg. N	0,7 11 1	18	0.880
	1. Decedent's Name (First, Middl	le, Last)						2. Date of D Month		ay	Year	3. Time of Death
an cal ⊲	Do	orothy G.	Davidso	n				March	0		2008	10:40 a
ier	4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, To	wn, or Loc	ation of Deat	h	4	c. County	of Death	
	Hebrew Home of	Greater Wa	shington			Rockv				Mo	ntgome	ery
	5. Social Security Number	6. Sex 1 □ M 2 🗷 F	7. Age (In yrs.		If Under 1 Months [		Under 24 Hrs ours Min.		irth <i>ay, Ye</i> a	r)	9. Birthpl	lace (State or Fore try)
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	Usual Residence of Decedent  10a. State 10b. County	/	10c. Cit	y, Town or Lo	cation						10	0d. Inside City Lin
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l J	David Davidson -	- Husband		5450	Whitley	Park	Terrace	, #802, B	ethes	sda, M	arylan	nd 20814
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To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any leading the cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   Ye	a. Due to b. Due to c. Due to d. Due	each line.  Lioba a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence of or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequen	uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence	Ectopic preg Other (spec	nancy ify)  26. Other: Injury at Work? 1   Yes	Part I.  Place of De  Nursing I	23e. Did 1 24a. Wa autu per 1 Yes ath (Check only) 28d. Describe	tobacco  Yes  s an opsy formed?  one) sidence a how inj	23d. Date Mor	e of deliventh  all Prob.  Were autoprior to conleath?  Yes  er (Specifyed)	Approximate Interval Between Onset and Death  PLU MUTE  Pry Day Year  Day Year  Day 4 Unknown  Day findings availance of cause  2 No
Certification: To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any least of cause (Sicase) (Sicase) or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to b. Due to c. Due to d. Due	each line.  Lio o o (or as a consequence of or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence	uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  ER/Outpatier  28b. Time of Injury  pme, farm, str	Ectopic preg Other (special and and and and and and and and and and	nancy ify)  26. Other: 4. Injury at Work? 1   Yes	Part I.  Place of De  Nursing I	23e. Did  1 24a. Wa auto per 1 Yes ath (Check only) Home 5 Res 28d. Describe 28f. Location City or To	tobacco Yes s an opsy formed? Tone) sidence how inj (Street & own, Sta	23d. Date Mor	e of deliventh  all Prob.  Were autoprior to conleath?  Leath?   Approximate Interval Between Onset and Death Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published P	
To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any leading the conditions of the cause. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. 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Time of Injury  pme, farm, str	Ectopic preg	nancy ify)  26. Other: 4. Injury at Work? 1   Yes	Part I.  Place of De  Nursing I	23e. Did  1 24a. Wa auto per 1 Yes ath (Check only) Home 5 Res 28d. Describe 28f. Location City or To	tobacco Yes s an opsy formed? cone) sidence how inj (Street a own, Sta	23d. Date Mor	e of deliventh  all Prob.  Were autoprior to confeath?  er (Specifyed)  er or Rura.  nner as stand due to	Approximate Interval Between Onset and Death Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published P
Certification: To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. 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Time of Injury  pme, farm, str	Ectopic preg	nancy ify)  26. Other: Unity at Work? 1 Yes  the time, do non opinion icense nur	Part I.  Place of De  Nursing I	23e. Did  1 24a. Wa auto per 1 Yes ath (Check only) Home 5 Res 28d. Describe 28f. Location City or To	tobacco Yes s an opsy formed? cone) sidence how inj (Street a own, Sta	23d. Date Mor	e of deliventh  all Prob.  Were autoprior to confeath?  er (Specifyed)  er or Rura.  nner as stand due to	Approximate Interval Between Onset and Death Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published Published P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Year 3:25 am 3/2/2008 Blanche Hurley Eslin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's <u>Laurel</u> If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 M 2 X F 578-34-7102 Director 79 Washington, D.C 1/23/1929 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director MD Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 4910 Lexington Ave. 20705 Funeral U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be l and 2 should be fi. lealth and Mental H m 27 is marked ott William W. Hurley 2 Gladys Barkes 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2
sort of Health ar
int; if item 27 is "
vor oth" 1195 Hoods Mill Rd., Cooksville, MD 21723 Gladys Arlene Taylor, Sister Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 3/5/2008 Washington, D.C. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. stance ton Hyattsville, MD 20781 ases Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Acute Myelomonocytic Leukemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No page 2 certificate 1□ Yes Physiclan: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 1 🖾 Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Matural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ຸກ 24 hou₁. ພາຍ Funeral ເົ the Hospital 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O lucest ans D23743 March 2, 2008

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Maryland 21215-0036

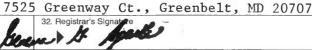
Baltimore,

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year)
MAR 0 5 2008

Martin Weitz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Francis W. Fox 10:05 PM March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** La Casa Assisted Living Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2 □ F 046-14-8324 82 Director April 18, 1925 Connecticut Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2 ZotNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 930 Astern Way, #405 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc within 72 hours after 1% Yes 2 No If Yes, Give 1943–47 Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€No Specify: White 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed M-dical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Architect Architecture is 2 should be filed whand Mental Hygier Is marked other ti injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred J. Fox Katherine Ginnane 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau Julianne J. Fox/wife 930 Astern Way, #405 Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State **K**Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) River Bend Cemetery 3/6/2008 Westerly, RI 21. Signalus of unural Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 1000 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Bilateral pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Dementia, progressive and burial-tra be exect Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2√No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate I Vital 1 Yes 2 No 26. Place of Death (Check only one) Assisted Living director. 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6XXOther (Specify) P 1 🗌 Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA o this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 Pending investigation 1XXNatural Injury the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

the the ပ

9

State

Registrar

Dr. Lucinda Mundorf

29c. License number 705 29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

116 Defense Highway #400 Annapolis, MD 21401

31. Date filed (Month, Day, Year)

29b. Signature and tifle of certifier

MAR 0 3 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year P29 Μ. 2008 Urith Fogle 2:07 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕅 F Yrs. Director 87 214-10-1111 May 24, 1920 Maryland Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at or than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified 1 X Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 200 E. Seventh Street Funeral 21701 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If item 27 is marked other th
any Injury or other therems. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvie H. Cecil 2 Nellie R. Haifleigh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Fogle / Son <u> 200 E. Seventh Street Frederick, Maryland 21701</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) March 4, 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery 2008 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, sumplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lun Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician Physician/Medical as the for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate has 1∐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 🔀 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Box 68760,

Division or Vital Hospital or Attending

within 24 hours after death To the Funeral Director:

State Registrar

Medical

29a. Certifier

29b. Signature and title of

M.D.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D58391

29d. Date signed (Month, Day, Year)

March 5, 2008

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per

and manner stated.

Frederick, Maryland 21701

Sajjad Aziz 31. Date filed (Month, Day, Year)

2008 MAR 05



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** NORMA JESSIE FAZENBAKER 2008 M MARCH 11, AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 106 GREEN STREET ALLEGANY WESTERNPORT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗙 F 219-14-5060 Director 29, 1922 WEST VIRGINIA AUG. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No MD Director ALLEGANY WESTERNPORT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 GREEN STREET 21562 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2/2 No Specify Specify: þ 3 Widowed 4 ☐ Divorced WHITE Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEXTILE LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LLOYD LAMBERT MATILDA CATHERINE (HALTERMAN) LAMBERT ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE PRICE DAUGHTER 106 GREEN STREET, WESTERNPORT, MD 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State RESTLAWN MEMORIAL GARD Mar 14 08 | LAVALE, MD 22. Name and Address of Facility 21. Signature of Funeral Service HAFER FUNERAL SERVICES, PA 1302 NATIONAL HWY., LAVALE, MD Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause in each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner CUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 1∏ Yes 2010 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

filed within 72

2 should be finance and Mental H

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any Injury or other them.

is marked other

certificate be executed burial-transit and attending physician the as nse ŏ the detached has page 2 certificate this After Attending death. after death completely filled in by the within 24 hours a

To the Funeral I Hospital

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number PITYSICIAN

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUMBINUAND MD 21502 912 FTON DRIVE

State Registrar

Medical

31. Date filed (Month) Day 32. Registrar's Signature

LOVITZIA

DHMH 17 Rev 1/2001

To the

Registrar

State

Z

ANUSHA IYER, SAINT AGINES HOSPITAL, 900 S.CATON AVE, BALTIMORE, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 0 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11 12

			1 - For State Registrar	State of Ma	aryland /				Death	wen		giene ( leg. No.	JUÖ	00014
	Physici	an	1. Decedent's Name (First, Middle, Las Eugene F. Finegan	1)						1	Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. Cit	y, Town, or	Location of Dear		rch l	_	Sunty of Deat	1:45 P ™
			Montgomery Genera	l Hospital	L		011	ney				Mon	tgomer	у
Į	Funeral Director		5. Social Security Number 6. Se 579-48-9436	X M 2□F	9 (In yrs. last t	oirthday) Yrs.		er 1 Year Days	If Under 24 Hrs Hours Min	7	Date of Birth Month, Day	, Year) 190		pplace (State or Foreign untry) Jersey
	ow III		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
:	e Mary	ctor	Maryland Montgome	ry	Sandy	Spr	ing							1 ☐ Yes 2 承No
3	death with the Maryland ms 23a or 28e-f show rrust be notilled at	Funeral Director	10e. Street and Number 1637 Hickory Knol	l Drive				ip Code 20860				_	n of What Co d Stat	
0000	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mendal Hygiene. I the Marylan (Hem. 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 X Yes 2 1 N Yes, Give Year or Dates:	wo World				ispanic Origin? (S in, Mexican, Puer Specify:	Specify to Rica	Yes or No- n, etc.)		Race - Ame Black, White pecify:	
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7	within then the Mac	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		sic:		during most of wo	9		Medi	cine	
מנומ	ai Hyg d other	BeC	17. Father's Name (First, Middle, Last)						18. Mother's Na			Maiden St	ımame)	
y d	marke marke	2	Michael Finegan  19a. Informant's Name/Relationship (7	vpe. Print)	19	- Mailir	na Addre	ss (Street	Agnes			r. City or 7	own. State. Z	ip Code)
, war	and 2 s alth an 127 io er treu		Maura F. Chelini						d Road,					
more	permit. Pages 1 and Department of Heali important: If item 2 eny injury or other 2005.		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1 /	of Dispo Crem Crem	781110	an plac		ch 2	2,		andria	Fown, State  Virginia
Dallillor	Departn Imports eny inju		21. Signature of Funeral Service Licen		$\neq$ \	10	E. Name	and Address Deer	ss of Facility D Park Dr	eVo: ive	, Gai	eral thers	Home,	MD 20877
i			23a. Part1. Enter the disease, or comp shock, or head (ailure. List only of	lications that cause one cause on each lir	the death. Do	o ot ent	er the m	ode of dyin	g, such as cardia	c or res	spiratory ari	rest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause Final disease of condition resulting in death)	a	ointest		. B16	ed						
į E	Examiner		Sequentially list conditions.	b. Pneumo	onia									
₩.	nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		a consequenc		Card	li ova:	scular D	isea	ase			
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00/00	nicate to physical stre b	edical	•	d										
YOU !	death certifi attending	clan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □Live birth	2 Fetal dea			pregnancy				23	d. Date of del	very Day Year
5	ine dea y the a	Physic	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 [	Other (	specify)						
בי, בי	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	þ	Part II. Other significant conditions co	entributing to death b	ut not resulting	j in the u	nderlying	cause give	en in Part I.					the cause of death?
scores,	aw requisits been 2 shoul	ompleted									24a. Was a		24b. Were au	topsy findings available completion of cause of
	cate ha	Com									perfor	rmed? 21 No	death?	2 No
V 150	certif	o Be	25. Was case referred to medical examiner?	Hospital: 1 🔀 Inpatie				Oth	26. Place of De					
5	ig Physical distribution	1	1 ☐ Yes 2 ⁴ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		. Time of Injury		28c. Injun Wor	4 🗆 140131119		Describe h			ciry)
	ttendir death. tor: Af the fur	catic	2 Accident investigation 3 Suicide 6 Could not be				M	10	Yes 2□No	28f	Location (S	treat and	Number or Ri	iral Route Number,
2	tal or A rs after al Direc ed in by	Certification:	4 Homicide determined	28e. Place of Injuding, et	c. (Specify)	iariii, str	eet, lact	ory, omce			City or Tow			\$
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;	withir To th comp	Me	29b. Signature and title of certifier	>11			2	9c. Licens					signed (Mont	
\'	vtI		30. Name and address of person who	1 Silly	leath /lto= 00-	) /Tuna	Drine'	034	190		l l	March	2, 20	U8
(			Joseph Garrett Re:	illy, M.D.	, 1151	0 01	d Ge	orget	town Rd.	, Ro	ockvil	lle,	MD 208	52
	Sta		31. Date filed (Month, Day, Year) MAR 0 4 20	32 legistr	ar's Signature	1	ast		-					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Amended item#5 3.5.08, SLU, WCHD ertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vasi **Physician** MARCH 23:40 P. M FITZE JR. 2008 CHARLES 0. /Medical 4c. County ol Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BERLIN
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. DEC. 13, 1921 ATLANTIC GENERAL HOSPITAL WORCESTER 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months MARY LAND 1⊠M 2□F 86 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show r then "natural", or items 23e or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Directo DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? USA 19975 37020 BLUE TEAL ROAD death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LIQUOR DISTRIBUTOR SUPERVISOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked o KATHERINE E. ARNOLD ٥ CHARLES O. FITZE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37020 BLUE TEAL ROAD, SELBYVILLE, DE 19975 MARK L. FITZE/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department o Importent: If eny Injury or pnce. CREMATORY OF DELMARVA | 3/3/08 DELMAR, DELAWARE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Buyer HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 MO 1543 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respirators arrest, shock, or heart failure. List only one cards on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) 2340 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed A. 0 Due to (or as a consequence of): 0. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 ☐ Unknown ፩ نه 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 76% Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes Vital Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death [Check only one] Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ٩ 1 🗌 Yes 28a. ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending 1 Tes 2 No death. investigation 6 ☐ Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide ö To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Daye signed (Month, Day, Year) 29b. Signature and title of certifiq 23a) (Type, Print) Date liled (Month, Day) State 4 2008 MAR 0 Registrar

12/13/2

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar			f Maryla			t of H	lealth a			/gien	68h 175	108	08616
	Phys	sician	1. Decedent's Name <i>(Fir</i> s Gerald	t, Middle, Last Gaskil								2. Date of De Month	eath Da	7,	Year	3. Time of Death
		edical	4a. Facility Name (If not in			nhorl		4h City	Town or	Location of		Februa			2008 ty of Death	2:00 P M
	Exam	miner	Suburban Ho	-	street and nai	noer)			hesd		Death		1		gomery	7
	Funer	ral	5. Social Security Number	r 6. Se		7. Age (In yrs	. last birthday,	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi (Month, D			9. Birthp	lace (State or Foreign
	Direct		578-74-2054		XM 2□F	80	Yrs.	Months	Days	Hours	Min.	11-30-	1927	,	Trini	iny) Ldad& Tobago
	and w		Usual Residence of Dece 10a. State 10b.	dent County		10c. C	ity, Town or Lo	ocation							1	0d. Inside City Limits
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	Maryland 21215-0036 and 2 should be filed within 72 hours aff the and Mental Higiene. 27 is marked other than "natural", or traumatic event, the Medical Exami		19a. Informant's Name/R	elationship (Ty	pe. Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	Route Numb	ber, City	or Town	n, State, Zip	Code)
i	and and ealth m 27		Marietta Ga		Wife			6th					shin	gto	n, DC	20012
	<b>Baltimore</b> , sermit. Pages 1 ar Department of Hea mportant: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 【X] Crer		Removal from	Siale I	Place of Dispo cemetery, cre					ate	20c. L	.ocation	- City or To	wn, State
;	I <b>tim</b> it. Pa rtmen rtant: njury		4 Donation 5 0			Met	tropoli								dria,	
Ī	Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce	21. Signature of Funeral	Nas	hal	L						Was:				ne, Inc. 20011
	Physicia	_	23a. 11. Enter the dise shock, or heart failu Immediate Cause (Final disease or condition	ease, or compl re. List only o	ications that c ne cause on e s. Seps	_	th. Do not en	ter the mod	e of dyin	g, such as	cardiac or	respiratory a	arrest,		Į	Approximate Interval Between Onset and Death Jnknown
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7	COLOS, P w requires that been signed t should be deta	þ	Part II. Other significant of	conditions cor	ntributing to de	ath but not res	sulting in the u	nderlying ca	ause give	en in Part I.						ne cause of death?
O	> 4 %	Completed										24a. Was	an	24b	. Were auto	psy findings available
£ 5	# 6	E										auto perfe 1 Yes	ormed?		prior to cor death? 1 🗌 Yes	npletion of cause of
Ser A	VICAL PRICIAN: SICIAN: The certificate rector, pag	Be (	25. Was case referred to examiner?	<b>⊢</b>						26. Place	of Death	(Check only				
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	- 0 0	on:	27. Manner of Death 1 XNatural 5 □	Pending	28a. Date of	of Injury h, Day Year)	28b. Time o Injury		8c. Injury Work			8d. Describe	how inju	iry occu	rred	
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	Go		30. Name and address of Pedele Gome	person who co		of death (Iter						814				
	S Regis	State strar	31. Date filed (Month, Day	(, Year)	32. Re	egistrar's Sign	ature									

State of Maryland / Department of Health and Mental Hygiene 0861 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year D: 59 M March William Edgar Grams 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstowii

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Pays | Hours | Min. | May 2, 1926 Washington County Hospital Washington Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F 81 Director 220-18-3152 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f sh notified 1 □Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 10917 Gaywood Drive 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX es 2 □ No 194 If Yes, Give Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1944-3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Ş 3 Widowed 4 Divorced 1946 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Lee Rosell Grams Dorothea Anna Humrichouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 21740 <u> Alma R. Grams - Wife</u> 10917 Gaywood Drive Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) any injury Mar.7,2008 | Sharpsburg, Maryland View Cemetery 21. Signature of Funeral Service Licens OSBOTHE ATOMISE Facility Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE LENAL MAIL URF WEEK! disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 WEEKS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner WEEKS BOWEL NECROSIC burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical VOLVULUS 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHAGNIC OLSTAULTIUS PULMONAMS DUSHES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 □ No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO 00 1040 03-63-200R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-10+1 COHON 322 E. ANTIGT PM HAGENSTOWN, MD 21740 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 28, 2008 Jean S. Glascock 8:41 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 120 Merryman Ct. Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 96 Director 224-60-6294 2/19/1912 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Merical Examiner must be notified at 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland| Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Merryman Ct. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ew Earl L. Shibler Nora Conn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Newman/ Son 5781 Sunset View Ln., Frederick, MD 21703-7243 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Senice Licensee 4 □ Donation 5 □ Other (Specify)

21. Signature of the Service License 3/1/08 Kalas Crematory Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ementia disease or condition resulting in death) VEAT /Medical Due to (or as a consequence of): Examiner pertensix Sequentially list conditions, any training to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi law requires that the death certificate be executed Hmal Fibrillation and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ To 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the Division or Vital Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy perform certificate 1∐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28d. Describe how injury occurred or Attending Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes death. 2 □ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after filled in within 24 hours a To the Funeral D the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

31. Date filed (Month, Day, Year) MAR 0 3 2008 Registra

ature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dalinand Rainten mb 3169 Broverton Stesse 201 Edbewset, mo

DHMH 17 Rev 1/2001

29c. License number

D0036371

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Edward Gill 2008 March 9:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3760 Telegraph Rd., Apt. E1kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 222-66-7328 41 Director April 3, 1966 Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Cecil E1kton 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3760 Telegraph Rd., Apt. 2 21921 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald R. Gill, Sr. Margaret Mattson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Gill, Sr./Father 3760 Telegraph Rd., Apt. 2., Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New London Methodist Cemetery 4 Donation 5 Dother (Specify) New London, PA 21. Signature of Puneral Service Licensee 22. Name and Address of Facility R.T. Foard and Jones, Inc. 122 West Main St., Newark, uchaso 23a. Pa 1. Enter the disease, or compline ons that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest strok, or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acce mysical /Medical Due to (or as a consequent e of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed model attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ Yo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 □ No within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) the chie Han MD D04823 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OKfor Ud 21921 main st CHIH HSU, MJ 223 west 301 32. Registrar's Signature 31. Date filed (Month State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Evelyn M. Grigsby March 1 2008 11:56 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5955 River Road Bryans Road Charles 8. Date of Birth (Month, Day, Year) NOV. 22,1924 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days Hours 1 □ M 2 🖫 F 212-08-4717 83 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notifled at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5955 River Road 20616 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☐ No Specify: <u>Ş</u> Specify: White 3 Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 8 Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Noble Frank Penn ပ Sussie Blanche Pickerall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra June Garrett Daughter 8561 Gunston Road, Welcome, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6, 2008 Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral S or complications the aused the death. Do not enter the mode of the grant of sardiac or respiratory arrest, ist only one pure on each line. 23a. Part1. Enter the dishock, or heart Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Deat Death Physician /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autonsy certificate 2 X No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu within 2.

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 X Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Medical

31. Date filed (Month, Day, Year! State

29b. Signature and title of certifier

ss of person

2008

Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Esther Glover A. 2008 9:05p March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carrol] Lorien Nursing Home Taneytown Birthplace (State or Foreign Country) Year If Under 24 Hrs. If Under 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 ☐ M 2 ☐ F 89 Director 4-4-1918 Delaware 213-01-7315 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State r 28a-f show notified at 1 ☐Yes 2 ☐ No Director Baltimore Pikesville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number be r 601 Upland Road 21208 USA ns 23a Funeral ral", or items 2 Examiner mus 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white Completed by 3 Widowed 4 Divorced 'natural", 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental I ant: If Item 27 is marked of Roy G. Newton Ethel Wright P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond P. Glover, son 2540 Coon Club Rd., Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages Department of Important: If II any Injury or once. Lake View Memorial Pk. 3/6/08 Sykesville, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee Lemmer 934 South Main St., Hampstead, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the a should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 🔀 No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient P After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Funeral Director: tely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 h To the Fu and manner stated.

NIT

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed

madd than

0

32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State amend #23e Per Phy G877 3/18/08 III
Reg. No.

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav AVILAND **Physician** MARCIA CIN OL 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 27 S. Bruce Street Laure1 Anne Arundel If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Min 1 M 2 □ F 218-56-6242 57 9/16/1950 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 27 S. Bruce Street 20724 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Parts Driver Carquest or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmund B. Haviland 2 Mae Sinclair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Barbara E. Haviland, Wife Bruce St., Laurel, MD 20724 S. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/3/2008 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 danno 23a. Part1. Enter the disease, or complications that caused the death. Do for enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ean 20 /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 2**XX**10 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No Physiclan: The 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 2 No 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death. 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR (S)

State Registrar MAR 0 5 2008

30. Name and address of person who

32. Registrar's Signature

21401

441

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Theodore W. Hughes **Physician** March 2 2008 ear 03:31А м /Medical 4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital 4c. County of Death Montgomery 4b. City, Town, or Location of Death Examiner Takoma Park 5. Social Security Number 579-46-7104 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March6, 1934 Months Days Hours **1X** M 2 □ F Yrs. Virginia Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or items 23a or 28e-f showing Medical Examinari - ust be notified at DC Washington 1 XYes 2 ☐ No Director 10e. Street and Numbe 10f. Zip Code 20018 10g. Citizen of What Country? 3298 Fort Lincoln Dr.Apt102 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other then "neturel", or Ite ☐Yes 2 MNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black δ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Private Business custodian other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Delbert Scott Naomi Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwen Y. Sutton - Sister 5727-5th Street NW Washington, DC20011 March10, 2008 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages Department of Importent: If it eny injury or c remetery, rematory or other place)
ThessaloniansBapt
Church Cemetery 1 

Burial 2 □ Cremation 3 □ Removal from State ForkUnion, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Robinson Funeral Home13136thSt.NWWash.DC 22. Name and Address of Facility 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO PUL MMARY Physician /Medical Examiner CURIMINEY DUEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit END STAGE REMAL DISFINE on Dialysis Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 X No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director; After this certifica in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 ☐ No 1 patient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of ray kindmedge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) U4699 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 HAMILTON ST 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland / Department of Health and M  State Registrar  For State of Maryland / Department of Health and M  Certificate of Death	Reg. N	2002	08625
9	Dhusisis		1. Decedent's Name (First, Middle, Last)	Date of Death     Month     Date	ay Year	3. Time of Death
	Physicia /Medic	al	Ellen May Hockenberry	February	26,2008	1:06 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Baltimore Washington Medical Center  Glen Burnie	1	c. County of Death Anne Arun	
- 1	<u> </u>	3	5 Search Security Number 6 Sex 7 And (In urs last hirthday) If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	9 Rinth	place (State or Foreign
	Funeral Director		216-28-0404 1□M 2ÅF 74 Yrs. Months Days Hours Min.	(Month, Day, Yea, 3/22/1933	Mar	yland
	ow st		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary n-f sh ffied a	to	Maryland Anne Arundel Glen Burnie			1 □ Yes 2 X No
	in the	)irec	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Co	ıntry?
	23a c ust b	ral	214 Wood Hill Dr., Apt. B 21061		USA 14. Race - Amer	ioon Indian
000	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The file m 27 is marked other than "natural", or items 23a or 28a-f show if them 27 is marked other than "natural", or items 2 is not context the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 4 □ Divorced  1 □ Never Married 4 □ Divorced  1 □ Never Married 4 □ Divorced  1 □ Never Married 5 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 2 □ Married 1 □ Married 2 □ Married 1 □ Married 2 □ Married 2 □ Married 1 □ Married 2 □ Married 2 □ Married 1 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Marr	ecity Yes or No- Rican, etc.)	Black, White	
ל ל	72 hou "natura	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing   16b.	Kind of Business/l	ndustry
7	within iene. than the Me	dwo	Elementary/Secondary (0-12) 12th College (1-4or 5+) Operator		C&T Telep	hone Co.
2	other other ent, t	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, Maide		
<u> </u>	uld be Menta Irked Ific ev	To B		ca Amos		
<u>a</u>	2 sho and 1 is ma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Control of the Name of Street and Number or Rural Control of the Name of Street and Number or Rural Control of the Name of Street and Number or Rural Control of the Name of Street and Number or Rural Control of the Name of Street and Number or Rural Control of the Name of Street and Number or Rural Control of the Name of Street and Number or Rural Control of the Name of Street and Number or Rural Control of the Name of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number or Rural Control of Street and Number of Street and Number or Rural Control of Street and Number of Street and Number of Street and Number or Rural Control of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number of Street and Number			
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Dallimor	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		1 □ Burial 2 XI Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Kalas Crematory 3/4/	'08 Ed	gewater,	MD
סמו	permit. Depart Import any inj		21. Signal to of Funeral Project Lipensee 22. Name and Address of Facility German Solomons Isla	ınd Rd. Edg		
Ŕ			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)  a.   Crute my 0 carstal	chfail	in	19
	/Medical Examiner_		Due to (or as a consequence of):	in		, 0
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
	ecuted ind transit	Examine	Cause (Disease or injury that initiated events countries to the country of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of the countries of			
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ΩΩ	ificate g phys	edical	d.			
O. Box	death cel e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	ivery Day Year
7.	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ecords,	quires an sign uld be	ed by		1 ☐ Yes	2 No 3 P	obably 4 Onknown
Ť	The law re ate has bee page 2 sho	Completed		24a. Was an autopsy performed 1□ Yes 2	prior to death?	utopsy findings available completion of cause of 2 ☐ No
VITal	ician; certific ector,	Be	examiner? Hasnital: Other	th (Check only o e)	- Flori (0	· ·
ō	Phys r this ral dir	-T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in		CITY)
0	th. :: Afte	tion	1 Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division	l or Atter after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and place (Check only one)  A graph of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	, and due to the cause rred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 7	Med	29b. Signature and title of certifier 29c/Dicense number	29d.	Date signed (Mon	th, Day, Year)
}	Xad	V	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		jw . C	
	III.		Charles J. Wu, M.D. 1600 S. Crain Hwy., Ste. 106, G1	en Burnie,	MD 2106	1
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 0 3 2008  32. Pygistrar's Signature			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Janie Maxine Ha		S I- For State Registrar	tate of Maryla		artment of ertificate of		l Mental H		g. No. 20	03 0862
Physicia Medical Exami	in/	1. Decedent's Name (First, Midd	_{dle,Last)} ie Maxine	Hamm				2. Date of Death Month March 1, 2	Dav Year	3. Time of Death 2030 hrs
		4a. Facility Name (if not instituti 14 Wild Flower Way	on, give street and nu	ımber)	4	b. City, Town, or Port Deposit		1	4c. County of I	Death
Funeral Director		5. Social Security Number 218-70-2712	6. Sex	7. Age (In yrs. 50	last birthday)	If Under 1 Year Months Days		1.	h(MM/DD/YYYY)	Birthplace (State or Foreign Country)     Virginia
/ any		Usual Residence of Decedent  10a. State 10b. County			y, Town or Locati	on	<u>.l.,</u>		, , , , , , ,	10d. Inside City Limits
Maryland 28a-f show d at once,	Director	10e. Street and Number	ecil		F	ort Depo 10f. Zip Code		10	0g. Citizen of What	-
0036 within 72 hours after death with the Maryland siene. her than "natural", or items 23a or 28a-f show Medical Examiner must be notified at once.	펻	14 Wild Flower  11. Marital Status  1 × Never Married 2		cedent Ever in l		2. s Decedent of His es, specify Cuban			U . S - 14. Race - White,	American Indian, Black,
s after deat ural", or it	by Fune		ivorced If Yes, Give Ye or Dates:		1 16a Deceden	Yes 2 X No		work done	Specify:	White
136 hin 72 hour e. than "natu	Completed	Elementary/Secondary (0-12 Nine Years		1-4 or 5+)		ost of working life.	DO NOT use re		Amaco/M	aryland House ast, Maryland
215-00 be filed wit ntal Hygien rked other ent, the M	Be Con	17. Father's Name (First, Middl Bill	e, Last) Ly Frankli	n Hamm				Joanne	Maiden Surname) e Virgini	
MD 21 42 should th and Mer 127 is man	70	19a. Informant's Name/Relation Billy F. Hamm	nship (Type, Print) (father	·	20 PI	easant \	/iew Chu	rch Rd.,	, Port De	State, Zip Code) 21904 posit, MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner m		20a. Method of Disposition  1 X Burial 2 Crematic  4 Donation 5 Other		rom State	crematory or ot larford Mer	morial Gard	dens 03	Date /07/08	Aberdee	City or Town, State  n, Maryland
		21. Signature of Funeral Service	ce Li ensee	Den.					neral Hor 3-0766	
Physician /Medical *xaminer		23a. Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final disease)	se on each line. se a. <mark>Asphyxia</mark>			ne mode of dying,	such as cardiac	or respiratory arr	est, snock, or near	t Approximate Interval Between Onset and Death
Ì	er	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b	a consequence						
19W = =	Examiner	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	C. C. C.	a consequence	of):					
0, be executed sician and ourial - transit	dical	UNPENDED	d AMENDED						Lood Date of a	
Division of Vital Records, P.O. Box 68760 To the Hospital or Atending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	/sician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 ☐ Yes 2 ☐ No 9 ✔ U	the 1 Live 4 Preg	, outcome of pre birth mant at time of the	2 Fe	etal death 3 ther (Specify)	Ectopic pregi	nancy	23d. Date of o	Day Year
ords, P.O. Bo w requires that the de is been signed by the should be detached for	d by Phy	Part II. Other significant cond	ditions contributing	to death but no	t resulting in the	underlying cause	given in Part I.			oute to the cause of death?  Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after ceath.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed							24a. Was auto perfo 1 <b>V</b> Yes	psy pr prm <u>ed</u> ? de	vere autopsy findings available for to completion of cause of eath?  Yes 2 No
Vital Rec ysician: The l his certificate l	Be	25. Was case referred to medie examiner?	cal Hospital:	Inpatient 2	ER/Outpatien		of Death (Chec	k only one)	Residence 6	Other: Scene
ion of Vii tending Physi eath. ior: After this	tion: To		28a. Dat FOUN	e of Injury th. Day,Year) D:	28b. Time of FOUND: 2030 hrs	Injury 28c. Inju	ry at Work? Yes 2 ✔ No		how injury occurre	
Divisior Hospita or Attend 24 hours after cleath Funeral Director: stely filler in by the	Certification:	3 Suicide 6 Co	oute not be		t home, farm, stre	et, factory, office	building, etc.	or Town.		er or Rural Route Number, City eposit, Md.
D To the Hospital within 24 hours To the Funeral completely filler	Medical C	29a. Certifier 1 Certifying	Physician: To the be xaminer:On the basis	s of examination	edge, death occu n and/or investiga	rred at the time, d	ate and place, and n, death occurred	nd due to the cau d at the time, date	ise(s) and manner a and place, and di	as stated. ue to the cause(s)
F 3 F 3	Me	29b. Signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the signature and the		M		29c. Licen: O.C	se number M.E.		29d. Date signe March 3, 20	ed (Month, Day, Year) 2008
3		30. Name and address of pers Melissa Brassell, MI				Penn Street, I	Baltimore, M	D 21201	•	
S Regis	tate trar		2008	Registrar's Sign	ature	W				
DHMH 17 Rev 1/2	2001		OCME		ORIGINA	<b>NL</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Marie Edna Hammett 2008 3:00 March 4, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lorien Assisted Living Mount Airy Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Hours 1 ☐ M 2 ☐ XF 216-20-2791 82 20, 1926 Maryland Jan. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 X Yes 2 □ No Directo Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 713 Midway Avenue - Apt. 230 U.S.A. Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iene. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If item 27 is marked other I any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace  $\mathbf{F}_{\bullet}$ Hammett Elizabeth Margaret Weigman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042Frank H. Hammett - Son 4060 St. Johns Lane, Ellicott City, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematorium 3/5/08 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Litensee Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician YKS /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy OBSHO ESOPREGER 26. Place of Death (Check only one) 25. Was case referred to medic a examiner? funeral director, Be 2ET No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

24 hours after death Funeral Director: filled in by the Hospital or

within 2 To the I

State Registrar

Medical

29a. Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Reilly, MD 801 Toll House Ave, D-1, Frederick, Md 2170/

MAR 0 5 2008

Physicia /Medica	- 1	For State Registrar		Cei	rtificate of I	Death	Re	g. No.		
		Decedent's Name (First, Middle, I	Last)				2. Date of Deat Month		Veer	3. Time of Death
	_	LYNDA SUSAN HAIS	SLIP				MARCH	Day <b>1</b>	Year 2008	10:45 AM
Examine		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death		4c. County	of Death	
LXuIIIII		130 KIRWAN'S LAN	NDING LANE		CHESTE	R		QUEEN	ANNE '	'S
Funeral			. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birthpla Counti	ace (State or Foreign
Director		215-52-6462	1□M 2 <b>X</b> F	58 Yrs.	Months Days	1.00.0	JUNE 21	, 1949		NGTON, D.
>	-	Usual Residence of Decedent  10a. State 10b. County	100	c, City, Town or Lo	cation		1		10	d. Inside City Limits
shov d at	.									1 ∐Yes 2 X No
28a-f otifie	- A -	MARYLAND   QUEEN A	ANNE'S	CHESTER	10f. Zip Code		1	0g. Citizen of	What Count	n/?
a or i		10e. Street and Number				10		Ü		
is 23 must	- t	130 KIRWAN'S LANI	12. Was Decedent Ever	rin U.S. 13.1	216 Was Decedent of H			JNITED 14. Ra	ce · America	
item	S	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?	0.0.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ck, White, e	
l", or	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specia	y: WHI	TE .
atura cal E		15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation during most of work	vian I	16b. Kind of E	Business/Indi	ustry
Medi "	ple	(Specify only highest (Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most or worr d)	Ving			
giene the	Completed	, , , , , , , , , , , , , , , , , , , ,	1	SA	LES			RETAI		
al Hy othe	Be	17. Father's Name (First, Middle, La	ast)			18. Mother's Nam	e (First, Middle,	Maiden Surna	me)	
Mental arked o	힏	ROBERT DIEHL				ERMA MI				*-
if Heatih and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	(Type. Print)			and Number or Ru				
n 27 n 27 ier tr		LISA A. DIEHL/SI				LANDING				
		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce) MARC	Date H 3	20c. Location	- City or Tov	vn, State
Department of Important: If any Injury or once.		4 Donation 5 Other (Spe	ecify)	CHESAPEAL	CE CREMAT	ION 2008		STEVENS	VILLE,	, MARYLAN
Depart Import any Inj once.		21. Signature of Funeral Service Li	censee	TRO I	2. Name and Addre	ess of Facility <b>ELFENBEIN</b>	I AND NEW	JNAM FI	NERAL.	HOME, P.
ysician Medical kaminer s the prival-transit	Examiner	Immediate Cause (Fina disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease of 197) that initiated events resulting in death) Last	a. Due to (or as a co		Meta	Newf	en e			
sician									ŀ	
ng phys as the	Medical		Q							
been signed by the attending should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у			ate of delive	ry Day Year
deta		Part II. Other significant condition	s contributing to death but n	ot resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?
sign Id be	d by						1 🗆 Y	es 2X No	3 ☐ Prob	ably 4 □Unkno
beer	Completed						24a. Was a	an 24b	. Were auto	osy findings availa
e has	m						autop	sy med? 2 <b>X</b> No	prior to cor death? 1 \( \sum \text{Yes} \)	
is certificate hadirector, page	Ö	25. Was case referred to medical				26 Place of Dea	1  Yes ath Check onl o		I LI Tes	2   NO
rect	o Be	examiner? 1 ☐ Yes 2 🗶 No	Hospital:	2 ER/Outpatie	nt 3D DOA Oti	ner: 4 Nursing H			ther (Specifi	<i>(</i> )
두 등	$\vdash$	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe h			/
rtn. r: After e funera	Certification:	1 Natural 5 □ Pending 2 □ Accident investiga		ear) Injury		Yes 2 □ No				
ector by the	lfica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace of fillury	- At home, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and Nun	nber or Rura	l Route Number,
Dir.	ert	4 El tottilique	building, etc. (	opeony)			Oity of Tov	, o.a.e/		
5 to 0	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best of n examiner: On the basis of ex and manner stated	amination and/or i	th occurred at the t nvestigation, in my	ime, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and r	manner as st	tated. the cause(s)
e Fune letely fill	(0)	29b. Signature and title of certifler	1 111		29c. Licen	se number		29d. Date sigr	ned (Month,	Day, Year)
мitnin 24 hou. To the Fune сотрletely fil	ž	290. Signature and the greening								•
within 24 hours after death.  To the Funeral Director: A Completely filled in by the fi	M	29b, Signature and title & certain	SA		D0033	3293		MARCH :	3, 200	8
vithin 24 hou to the Fune completely fil	Me	30. Name and address of person w	who completed cause of deat	h (Item 23a) (Type		3293		MARCH	3, 200	8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** HUDSON 2008 -GRRUARY 28 ELLIOTT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HICOMICO 59/1564M ROGIONAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 2 🗷 F 78 MARYLAND JANUARY 30 1930 Director 218 24 4449 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No VIRGINIA ACCOMACK NEW CHURCH Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23415 WALLOPS MILLFOND USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No f Yes, Give fear or Dates: 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 🗷 No Specify: WHITE Baltimore, Maryland 21215-0036 ð 3 XWidowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hand Mental Hygiene. the HEALTH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GRAHM ELLIOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any Injury or other trau once. 7457 WALLOPS HUDSON NEW CHURCH MILLFOND KENNETH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State VIREINIA CEMETERY MARCHO3 08 OAK HALL 4 □ Donation 5 □ Other (Specify) DOWNINGS 22. Name and Address of Facility / Ex & HOLSTON TEUNGARE HOME 21. Signature of Funeral Service Licensee 5049 CHICKEN CITY RD. CHINCOTERGUE, VIRGINIA 23336 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical e to (or as a consequence of): Examiner TI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a conseque P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 💆 No 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2.2 No 1 Yes ynoide 25. Was ase referred to medic examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide hin 24 hours a the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

BA 8 State

Jeffrey Wieland
31. Date filed (Month, Day, Year)

32. Registrar's Signature

100 ERST CARROLL ST.

30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

S'ALISBURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:24 a^M March 01 2008 Lucille N. Hitt /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Arden Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 耳 F 88 Pennsylvania Director 170-16-8559 October 29, 1919 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 K No Director Silver Spring Maryland | 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 20904 U.S.A. 815 Venice Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Caucasian 3 X Widowed 4 ☐ Divorced Year or Dates: Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Velma King Olpha D. Newton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important; If Item 27 any Injury or other troonce. 815 Venice Drive, Silver Spring, Maryland 20904 Robert E. Hitt - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 03/05/2008 Rockville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. George 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 month Pneumonia /Medical Due to (or as a consequence of): Examiner 5 years Senile Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed 10 years Chronic Obstructive Pulmonary Disease Due to (or as a consequence of) burial-P.O. Box 68760. physician Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 2 No certificate 1 Yes 2 X No 1 ☐ Yes Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2▼ No 1 Inpatient 2 ER/Outpatient 3□ DOA ပ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 ☐ Homicide Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 3, 2008 D43237 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Drive, Suite 102, Laurel, Maryland 20707 Paul Armstrong, M.D., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 4 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Ma	ryland / De	epartmen Certificat			nd M	ental Hy	giene Reg. No.	2111	8	08631
i.	Physici /Medio		1. Decedent's Name (First, Middle Gloria J. Her								2. Date of De Month Februa	Day	Yes 3, 200	ar	3. Time of Death 8:50 a ^M
	Examin		4a. Facility Name (If not institution, Kensington Park			Communit	,		r Location of	f Death			County of D	eath	nery
7 / C	Funeral Director		579-24-9597	6. Sex 1 □ M 2 <b>x</b> □ F	7, Age	e (In yrs. last birtho Yrs	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Da June 4	ay, Year)		Country	ce (State or Foreign /) ington, DC
	filed within 72 hours after death with the Maryland Hygiene.  ther than "naturar," or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland  10e. Street and Number	Montgome	ry	10c. City, Town o	Lver S		g			10a. Citi:	zen of What		1. Inside City Limits 1 □ Yes 2★★No
	be filed within 72 hours after death with the Marylan ital Hygiene.  ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Di	9518 Riley Ro	12. Was Dec		Ever in U.S.	13. Was Dece If Yes, spe	2	0910 Hispanic Orig an, Mexican	jin? (Spe	cify Yes or No		JSA 14. Race - A Bleck, W		
21215-0036	2 hours afte latural", or i ical Examir	by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced 15. Decedent	If Yes, G Yeer or I		16a. D	1 ☐ Yes	al Occur	Specify:	of working	200	16b. Kir	Specify: W		
121215	iled within 7 Hygiene. her than "n nt, the Medi	Completed	(Specify only highes Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, I	College		+)	Give kind of wo fe. DO NOT u Iomemak				(First, Middle	4	Own Ho	me	
Maryland	× 2 2 2	To Be	Harvey Johnst  19a. Informant's Name/Relationsh	on		19b. N	Mailing Address	s (Street	Ruth	Cond	on			e, Zip C	Code)
	s 1 and 2 of Health a ltem 27 is	17	Douglas L. Henr  20a. Method of Disposition  1  Burial 2 □ Cremation		n State	20b. Place of D cemetery, Gate of		me of other pla	ce)	Mar	ch 5,	20c. Lo	ocation - City	or Tow	n, State
Baltimore,	permit. Page Department of Important: If any injury or once,	1 () 2 ()	4 □ Donation 5 □ Other (St. 21. Signature of Funeral Service I		le	Gate of	22. Name a	nd Addre	ess of Facility	, lins	2008 Funer	al Ho	ome In	c.	g, Maryland g, MD 2090
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any become to minimodate cause. Enter Underlying Cause (Disease or injury that initiated events	a. At Due to b. Ce	hero (or as reb	the death. Do not let.  DSCleroti e consequence of)  rovascula a nonnequence of) tension	ic Hear : ar Acci	t Di	sease	cardiac o	r respiratory a	arrest,		_	Approximate nterval Between Onset and Death
Box 68760,	leath certificate be executed attending physician and I for use as the burial-transit	Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	Due to	utcome birth	a consequence of)  pf pregnancy 2  Fetal death time of death	3 □Ectopic p		у				23d. Date of Month		y Day Year
ds, P.O.	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	by	9 ☐ Unknown  Part II. Other significant condition	9⊡Unk ens contributing to		ut not resulting in th	he underlying	cause giv	ven in Part I.						cause of death?
Il Records,		Completed									24a. Wa auto peri 1∐ Yes	opsy form <u>ed</u> ?	prior deat	to com	sy findings available pletion of cause of
n or Vital	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  27. Manner of Death  1 ☑ Natural 5 ☐ Pendin	28a. Dat	] Inpatie e of Inju	ry 28b. Tin	atient 3 Den	Oth 28c. Inju Wo	ner: 41 Nu	rsing Hor	(Check only me 5 ☐ Res 28d. Describe	sidence		Specify)	
Division or	To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide	ation ot be 28e. Place	ce of injuding, etc	ury - At home, farm c. <i>(Specify)</i>	M		]Yes 2⊡I		28f. Location City or To	(Street an own, State	nd Number o	r Rural	Route Number,
	the Hospita nin 24 hours the Funera npletely fille	Medical C	(Check only 2 Medical one)	Examiner: On the and ma		of my knowledge, of examination and/ ated.	or investigatio	n, in my	opinion, dea			e, date and	d place, and	due to	the cause(s)
	D # 6 8	4	29b. Signature and title of confidence and address of person	XXI	use of d	eath (Item 23a) (Ty			se number				te signed (N		
	Sta		Ajay Reddy, MD 31. Date filed (Month, Day, Year)	6320 E	emo	cracy Blv	vd. Bet	hesc	da, MD	208	17				
	Regist	ar	MAR 0 4	2008	PAR.	15 16	THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE S								

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ate of Maryland		rtment of F tificate of		nd Mental F	lygien Reg. N		8	08632
П			Decedent's Name (First, Middle, Last)					2. Date of				3. Time of Death
10	Physici		Helen May I	saacs				Febru		28, 200		9:55 AM
	/Medio		4a. Facility Name (If not institution, give street			4b. City, Town, o	r Location of I			c. County of D		
	LAGITITI	. *	Union Hospital of Cec	il County		E1kton				Ceci1		
	Funeral	9	5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of	Birth	9.	Birthpla	ce (State or Foreign y)
D,	Director		218-34-1835 1□ M 2	2 <b>⊠</b> F 72	Yrs.	Months Days	Hours	Min. (Month, May 2	Day, Yea.			ware
	D	2	Usual Residence of Decedent									
	rylan how lat	_	10a. State 10b. County	10c. City, 1	Town or Loc						100	d. Inside City Limits
	a-f s	cto	Maryland Cecil		Ris	ing Sun						1 ☐ Yes 2 🌠 No
	th th or 28 e no	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What	Countr	y?
	th wi		10 Mason Dixon Driv	re		21913	1		Uni	ted Sta		
	ems er m	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S. med Forces?	13. V	Vas Decedent of H	lispanic Originan, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A Black, W		
ဖွ	after or it		1 Never Married 2 Married 1	∏ Yes 2 <b>XX</b> No Yes, Give	1	□Yes 2√□XNo	Specify:			Specify:	Whi	
21215-0036	iours iral", Exa	d by	3 ☐ Widowed 4 ☐ Divorced Ye	ear or Dates:		1121	esc					
2	72 h "natu dica	Completed	15. Decedent's Education (Specify only highest grade com		16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	oation during most o	of working	16b.	Kind of Busine	ess/Indu	istry
2	/ithin ne. han e Me	ם	Elementary/Secondary (0-12)	ollege (1-4or 5+)	Homer		a)			Own Hon	ne	
7	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ပိ	17. Father's Name (First, Middle, Last)				18 Mother's	s Name (First, Mid				
Maryland	be fi	Be	, , ,					•		sii oumame)		
Ž	iould I Mer narke	2	Clifton Walls		405 84-115-	- Add (Ott		or Rural Route Nu		Town Ctar	4- 7i- (	2-del
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Pa Theresa Laird / Daug			-		rive, Elk				21921
ი ე	1 and Health		20a. Method of Disposition					Date Date		Location - City		
altimore,	iges it of B if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov	ai irom State		sition (Name of natory or other plac	1	March		,		
Ħ	t. Pa tmer tant: ijury		4 Donation 5 Dother (Specify)	Nort		st Method		3, 2008				Maryland
Bai	ermi Depar mpoi ny ir		21. Signature of Funeral Service Licensee			. Name and Addre		Crouch				1 101001
			1 part							East,		y1and21901 Approximate
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau									interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Novte nyo	rwd.	11 14f.	ve for	/				Jesj
	/Medical Examiner		resulting in death)	Due to (or as a consequent of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of	nce of):		2	2 -				/
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×	certifi ding se as		IF FEMALE: 23c If	yes, outcome pf pregnanc	·v					23d. Date of	dolivor	
Records, P.O. Box	atten for us	Physician/M	in the past 12 months?	Live birth 2 Fetal d Pregnant at time of dea	eath 3	Ectopic pregnanc Other <i>(specify)</i>	y			Month		y Day Year
o.	the a	/sic	1 Yes 2 XNo	□Unknown	5_	Joiner (specify) _			_			
σ.	w requires that the death certif been signed by the attending should be detached for use as	F.	Part II. Other significant conditions contribut	ing to death but not resulti	ng in the ur	nderlying cause giv	ven in Part I.	23e. D	id tobacco	o use contribut	te to the	e cause of death?
ds,	signe signe	by	COPO - Emphysema			, ,		1	Yes	2 No 3	] Proba	ably 4 🗆 Unknown
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2	: Th cate pag	Š	Diobetes Time I					1□ Y		1 1	Yes :	2□ No
Division or Vital	ician Sertifi ector	Be	25. Was case referred to medical examiner?	al· .		l O#	nor:	of Death (Check or				
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Ë	Ing F	ü	1 Natural 5 ☐ Pending	a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	Wo			be now in	jury occurred		
Sic	tend eath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	Discontinuo Athan			]Yes 2 □ N		/044			Paula Number
$\leq$	or At fiter d Direc in by	Certification:	4 Homicide determined	<ul> <li>e. Place of injury - At hom building, etc. (Specify)</li> </ul>	e, iarm, sire	eet, ractory, onice		City or	Town, Sta	and Number o ate)	or murai	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Ce	200 Cartifier 17 Cartifying Physics	at To the heat of my knowl	odge doct	000urrad at the 4	ime data and	Inlane and due to	the course	(e) and man-	21 20 04	ated
	Hos 24 ho Fun tely f	Medical	(Check only 2 Medical Examiner: 0	n: To the best of my knowl On the basis of examination	n and/or in	vestigation, in my	opinion, death	h occurred at the ti	me, date a	and place, and	due to	the cause(s)
	the the mble	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. [	Date signed (M	∕lonth. L	Day, Year)
	7 <u>×</u> ≥ 0		1 distall				15/9	40		-		2008
•	1.		aga Tung	1			5 5 1 1	/ ()	100	0477	00	
	0		30. Name and address of person who comple	1								
			31. Date filed (Month, Day, Year)	2. Registrar's Signatu	re #							
3	Sta Registr		MAD A 4 2008	here &	An							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar		State	e of M	arylar		artmen rtificat				lental Hy	giene Reg. Nó.	08	08633
ľ	Physici	an	1. Decedent's Name	e (First, Middle	e, Last)		_						2. Date of De Month	ath Day	Year	3. Time of Death
ı	/Medic			Jacoby									Feb.	25, 20	008	1:20 P M
1	Examin	er	4a. Facility Name (// Genesi:	f not institution S	, give street and	d number)			4b. City,	Town, or	Location	of Death		4c. Coun	ty of Death	
			Spa Cre			T = 4		for a blab do a	Anr If Under	apo.	lis If Under	24 Hrs	0.5.451		e Aru	
	Funeral Director		5. Social Security N 019–12–1		6. Sex 1 ☐ M 2🎇		98	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Apr. 2:	iy, Year)		place (State or Foreign intry)
_			Usual Residence of										npr. z	7,1907	GCI	many
	arylan	L	10a. State MD	10b. County	Arundel			ty, Town or Lo everna								10d. fnside City Limits
	Ba-1	octo		L	ar under		36	everna								1 Tyes 2 No
	be filed within 72 hours after death with the Maryland nial Hygiene. so other than "naturel", or Iteme 23s or 28s-1 show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Nur 394A Ma		Deo				10f. Zip	Code 2114(	=			10g. Citizen o	f What Cou	intry?
	eath ne 23	era	11. Marital Status	godiy i		Decedent	Ever in 11	S 13 1				nin? /Sn	acify Vas or No		ace - Ameri	ican fndian,
(0	fter d	Fun	1 Never Marri	ied 2□ Marr	Arme	d Forces?	,	1			n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	BI	ack, White	
21215-0036	ours a	by	3 Widowed	4 Divorced	If Yes	, Give or Dates:			1□Yes :	2X No	Specify:			Spec	ity: Wh:	ite
5-0	72 hc	Completed	(Spec	15. Decedent	's Education	ted)		16a. Deced	kind of wor	k done d	tu <i>rina m</i> os	t of work	ina	16b. Kind of	Business/Ir	ndustry
121	within lene. than "	mpl	Elementary/Seco		1	ge (1-4or	5+)	life. I	nemake	e retired	)			Home		
	e filed withln al Hygiene. I other than '		12 17. Father's Name	(First Middle	( ast)			HOI	icilare	<u>:T</u>	19 Mothe	r'e Name	/Eiret Middle	Maiden Suma		
Maryland	d be f antal h ted of	Be c	Walter								unk	ers Name	(First, Middle	Maideri Suma	lme)	
Z	should be nd Menta marked	T _o	19a. Informant's Na					19b. Mailir	ng Address	(Street a		er or Rura	il Route Numb	er, City or Tow	n, State, Zi	p Code)
	nd 2 aith a 27 is		Fred Jac	oby/ So	on			394A						rk, MD		
ore,	of Hear Item		20a. Method of Disp					Place of Dispo	sition (Nan	ne of	- 1		Date	20c. Location		
Ĕ	Page ment ent: ti		1 ☐ Burial 2]		3 □Removal fi pecify)	rom State		etro Cr				Feb. 20	08	Baltim	ore, M	Maryland
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Mente Importent: if Item 27 is marked any injury or other treumatic e ones.		21. Signature of Fu	neraf Service	Licensee	1		Ba 49	Name and Irrance 5 Gov	d Addres O &	Sons itchi	P.	A. Seve	erna Pai erna Pai	ck Fur	neral Home D 21146
ı			23a. Part 1. Enter the shock, or hea	he disease, or rt failure. List	complications the	nat caused	d the deat								1	Approximate Interval Between
25%	Pitysician		Immediate Cause ( disease or conditio	(Final		Osa	10-	onth	rite							Onset and Death
	/Medical Examiner		resulting in death)		Due	to (or as	a conseq	uence of):								7
		_	Sequentially list cor	nditions,	b	Ver	ren	tie	_							year
	ted nsit	nine	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or	flying injury	, Due	()	1	derice or).	100		F	- 1				, 1
	execunand nand	Examiner	that initiated events resulting in death) L		c. Due	to (or as	a conseq	uence of):	rcec	4	1-6	uce	سا			week
8760,	sate be executed obysician and the burial-transit	lcail			d				_							
9	rtifical ng ph	Jedi	IE EEMALE.													
Box	that the death certific ed by the attending p detached for use as:	by Physician/Med	1F FEMALE: 23b. Was decedent in the past 12		23c. If yes 1⊟Li	, outcome ve birth			lEctopic pre	gnancy					ate of deliv	ery Day Year
	ne dea the at	/slcl	1 Yes 2 Dunknown			regnant al nknown	t time of d	eath 5□	Other (spe	ecify)				N	TOTAL	Day 18a
P.0	that the od by detac	Ph	Part II. Other signifi	icant conditio	ns contributing	to death h	ut not res	ulting in the ur	derlying c	use awa	n in Part I		23e Did t	obacco use co	ntribute to t	the cause of death?
Vital Records,								J	raony ang oc	1000 g.10				Yes 2□No		
200	w require been si should b	Completed											24a. Was	an 24h	Were auto	onsy findings available
Re	The lave	дшо								_			autor	rmed?	death?	opsy findings available ompletion of cause of
<u>ra</u>		O	25. Was case refer	red to medical						-	26 Place	ot/Death	1 Yes		1 🗆 Yes	20 No
5	ysici iis cer direc	To B	examiner? 1 🗌 Yes 2 🗹	No	Hospital: 1	☐ Inpatie	ent 2	ER/Outpatien	t 3 DO	A Othe	. 1	6		dence 6 🗆 O	ther (Specia	fy)
0 0	Attending Physicien: or death. ector: After this certifical by the funeral director,		27. Manner of Death	n 5 ☐ Pending		ate of Inju	ry y Year)	28b. Time of	21	Bc. Injury Work				now injury occi		
Sio	ttendii death. ctor: A r the fu	catio	2 Accident	investig	ation				М	1 🗆 Y	′es 2 🔲 I	No				
Division of	or Attendate death	Certification:	3 Suicide 4 Homicide	determi	ned 288. P	lace of Inj uifding, et	ury - At ho c. <i>(Specif</i> )	ome, farm, stre y)	et, factory	office			28f. Location (: City or Tox	Street and Nun vn, State)	ber or Run	al Route Number,
_	pital		29a. Certifier	1 Cartifyin	g Physician: To	the heet	of my kno	wledge death	- annumed (	t the tim	o data aa	d place /	and due to the	201120(2) 224		ntate d
	e Hos 24 h e Fun	edical		2 Medical E	examiner: On the	ne basis of	f examina	tion and/or inv	estigation,	in my op	inion, dea	th occurr	ed at the time,	date and place	, and due t	to the cause(s)
	To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by	Me	29b. Signature and	title of certifier	1					_	number			29d. Date sign	ed (Month,	Day, Year)
	2 2	5	1 Ha	11/	(hu	0	m	0	ļ	25	311	1		2/	25	108
	VOON!		30. Name and addre	ess of person	who completed o	ause of d	eath (Item	23a) (Type, I	Print)			<del></del>				
	The		// Hu		Davis,		200	1 Med	ical	Pk	vy A	nnar	olis	MD 214	01	
	Star Registra		31. Date filed (Mont	h, Day, Year)	3 2008	2. Registra	ar's Signa	ture								
	negistra	21		MAK U	S 2000	J. J. C. R.	we	15 1	TO S							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Feb. 29^{Day} **Physician** 200⁸ Caroline Μ. Jessup 2030 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Yea. Sept. 14, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year) Country) Months Days Hours Min 1 □ M 2 🗓 F Sept. 71 190-28-5837 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 200. 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 ☐ Yes 2 ▼No Directo MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12924 McCubbin Lane 20874 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White þ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Secretary Public Schools 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willis Gerard Margaret Mulroe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Jessup (Son) 26301 Forest Vista Dr. Clarksburg, MD 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 3 1 Burial 2 Cremation 3 ☐Removal from State Metropolitan Crem. Alexandria, VA 4 Donation 5 Dother (Specify) 2008 22. Name and Address of Facility 21. Signature of Funeral Service Lice DeVol Funeral Home weter 10 East Deer Park Dr. Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Small Cell Lung Cancer 1 Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tra Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 🗓 No Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician: The law requires that the death certificate be executed funeral director, page 2 should Hospital or Attending death. 24 hours after death e Funeral Director: filled in by the

Division or Vital Records, P.O. Box 68760,

Manner of Death 1 X Natural 5 Pending investigation 2 Accident

6 ☐ Could not be 3 Suicide 4 ☐ Homicide

29a, Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year) March 2, 2008 D005317

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John M. Wallmark,

9707 Medical Center Dr. #300 Rockville, MD 20850

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 31. Date filed (Month, Day, Year) MAR 0 4 2008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

the

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Unpend/Amend PI line a b, 27,30, perMF, 887, 5114/08 114 and Mental Hygiene Registrar Amend#26. PerPhys. PGC3-13-08cr Certificate of Death Reg. No. 08635 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Feb 2008 29 1458 Keith Jackson 4c. County of Death Prince George 4b. City, Town, or Location of Death Andrews AFB 4a. Fecility Name (If not institution, give street and number) Andrews Malcolm Grow Med Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Sept. 14, 1972 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Dillon, S.C. 1**⊠**M 2□F 248-53-5861 35 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 No Prince George Andrews AFB 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2074 Jackson Rd. 20331 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Wes 2 No 6/90
If Yes, Give 3/08 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) US Army

Soldier/Supply

18. Mother's Name (First, Middle, Maiden Sumame)

22203

Margaret Townsend

Rockville, MD 20850, Terrill Tops

vrnit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examples in units of any injury or other traumatic event, the Medical Examples in units of any once. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

10a. State

Director

Be Completed by Funeral

၉

MD

17. Father's Name (First, Middle, Last) Charlie Jackson

**Funeral** 

Director

the Maryland

Pnysician /Medical **Examiner** 

To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funaral Diractor: A completely filled in by the fu completely

19a. Informant's Name/Relationship (Ty Stephanie Jackson			ress (Street and Number or F			te, Zip Code)
20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b. P	lace of Disposition emetery, crematory Hill Ame M.	ethodist Ch   3/8	Date /08	20c. Location - City Lakeview	
21. Signature of Funeral Service Licens  Mauth	Busch		e and Address of Facility hy FH 4510 Wi	lson Blv	d. Arling	ton, VA 2220
23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death ne cause on each line.	n. Do not enter the	mode of dying, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Ca	rdiac Sarco	idosis			
resulting in death)	Due to (or as a consequence					
	Sv	stemic sarc	nidosis			
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence		OIGODID			
Cause. Enter Underlying Cause (Disease or injury that initiated events						1
that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
	Due to (or as a conseq.	201100 017.				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	33c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I déath 3 □Ectop eath 5 □ Othe	inc cause given in Part I	23e Did t	23d. Date o Month	f delivery  Day Year  site to the cause of death?
Part II. Other significant conditions co.	ntributing to ceath but not res	underly	ing cause given in Faith.			Probably 4X Unknown
					rmed? dea	re autopsy findings available r to completion of cause of th? Yes 2 XNo
25. Was case referred to medical			26. Place of D	eath (Check only	one)	
examiner? 1 XYes 2 No	lospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 V si	dence 6 Other	(Specify)
27. Manner of Death 1 Natural 2 Accident	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury at Work?	28d. Describe	how injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		ctory, office	28f. Location ( City or To	Street and Number wn, State)	or Rural Route Number,
29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occu tion and/or investig	rred at the time, date and pla ation, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
29b. Signature and title of certifier			29c. License number		29d. Date signed (/	* * * * * * * * * * * * * * * * * * * *
New Contraction		-	NC133929		March	1, 2008

College (1-4or 5+)

State Registrar

102

32. Registrar's Signa

1413 Research Blvd, Bldg

31. Date filed (Month, Day, Year MAR 1 3 2008

Division or Vital Records, P.O. Box 68760, 24 hours after deatl Funeral Director: Hospital

filled in by hin 2

Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of

30. Name and addre

MAR 0 3 2008

completed cause of death (Item 23a) (Type, Print) 32. Rajistrar's Signature

and manner stated.

**ORIGINAL** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

132136

29d. Date signed (Month, Day, Year)

(3, Dough home Charle, NO 21665

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				1 - For Stata Registrar	State of M	arylar		artment <i>rtificate</i>			d Me		iene	08	08637
		Dharia		1. Decedent's Name (First, Middle, Last)							2	. Date of Deat Month	h Day	Year	3. Time of Death
		Physici /Medi		George David Kestr	ner, Jr.						F	Ebruary		2008	1238A M
		Examir	ner	4a. Facility Name (If not institution, give s		)		4b. City, 1	own, or	Location of D	Death		4c. Count	y of Death	
				Harford Memorial H				-		de Gi		2		larfor	
		Funeral		5. Social Security Number 6. Sex	7. A		last birthday) Yrs.	If Under Months	Days	If Under 24 Hours	Min.	(Month, Day,	Year)	9. Birthpt	ace (State or Foreign try)
		Director		235-30-8111 Usual Residence of Decedent		83					1	May 3,	1924	V1	rginia
		yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10	Od. Inside City Limits
- ;		Mar	ţċ	Maryland Ceo	i 1		Col	ora							1 ☐ Yes 2🌠 No
7		th the	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Count	try?
3		23a (	ai	60 Coulson Drive					21	917			USA	1	
7		r dea	nei		12. Was Decedent Armed Forces	Ever in U	.S. 13.	Was Decede	ent of His	spanic Origin n, Mexican, P	? (Specif	y Yes or No- can, etc.)		ce - America	
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ax.	Maryland 21215-0036	uld b Menta Irked	To	George David Kestn	er, Sr.					Mar	rgare	et Ann	Carlto	n	
63	an.	2 sho and I is ma		19a. Informant's Name/Relationship (Type	pe, Print)		19b. Maili	ng Address	(Street a	nd Number o	or Rural F	Route Number,	City or Town	, State, Zip	Code)
9		and ealth m 27		Eula Kestner/Wife						ive, (		ra, MD			
	Baltimore,	ges 1 i of H if ite		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ R	emoval from State		Place of Dispo cemetery, crea	osition (Nam matory or oti	e of her place	) 3-	Date 4-20-	008	20c. Location	- City or Tov	wn, State
	Ë	: Pag tmen tent: jury		4 ☐ Donation 5 ☐ Other (Specify)		R.	T. Foa							Sun,	Maryland
	Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic svent, it a Medical Examinat ministers invitibed at angle.		21. Signature of Funeral Service License	98	۵	l 2	2. Name and R • T •	Addres: Foar	s of Facility d Fune	eral	Home,	P.A.		
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00	9	artifica ing pl	Med	IF FEMALE:											
0	Вох	leath certifi ettending   I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth	2 Feta	if death 3	⊒Ectopic pre						ate of detiver	ry Day Year
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13	۵	thet the ed by detac	by Physician/Me	Part II. Dther significant conditions con	tributing to death t	out not res	ulting in the u	inderlying ca	use give	n in Part I.		23e. Did tob	acco use con	tribute to the	e cause of death?
2	Division of Vital Records,	Attending Physician: The law requires thet the death certificate redath. r death. ector: After this certificate has been signed by the ettending phys by the funeral director, page 2 should be detached for use as the	d b					, ,	•			1 □ Ye	s 2 No	3 Proba	ably 4 Unknown
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		To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificete ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1 Certifying Physical Examination	ician: To the best ner: On the basis of and manner st	of examina	owledge, deat ition and/or in	n occurred a vestigation,	t the time in my op	e, date and p inion, death c	occurred	d due to the ca at the time, da	ause(s) and mate and place,	anner as sta , and due to	ated. the cause(s)
		To the I within 2. To the I	Mec	29b. Signature and title of certifier	) and manner si	4100.		29c.	License	number		2:	9d. Date sign	ed (Month, L	Day, Year)
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	1			30, Name and address of person who co	_	death (Iter	п 23а) (Туре.	Print)							
1.	+1	VH		Vincent & Gimmaro			rth A		210	B	el Ai	r, und	2101	4	
		Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 4 2008	32. Regist		ature	2		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend It State of Maryland 1899 art 901 96 Hardth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)
Bessie Ka 2 Date of Death March 11, Kling 2008 Kathryn 4:05 AM **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden Living Center Frederick
If Under 1 Year 1 If Under 24 Hrs. Frederick 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace Country) (State or Foreign **Funeral** 1 □ M 2 🔀 F Yrs. 88 217-18-7030 May 7, 1919 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once. 1 → Yes 2 □ No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21702 1109 Key Parkway Apt.# 102 Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Hospital 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Wood Jessie Wood 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 207 Dora Dr. Myrtle Beach, South Carolina 29588 Larry M. Kling (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 13 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 NO1414 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dhitructive Pulmonary Disease Immediate Cause (Final disease or condition resulting in death) Chronic Physician /Medical Due o (or as a consequence of): Examiner nellmonia sequentially list of differential forms of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No 3 DEctopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed PINO To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and with

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 1 8 2008

32. Registrar's Signature

D006 2223

, 196 TJ DLIUE, FLEDBUCK, MD-21702

08-01544 Robert Ray Kessel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

bert Ray Kess	1-	- For State egistrar	ate of Maryla	and / Depa <i>Cei</i>	artment of tificate of	Health Death	and	Menta		R	eg. No.	201	0863
Physicia	n/ 1	. Decedent's Name (First, Middl	e,Last) Ray Kesse	1						Date of Dea Month		Year	3. Time of Death 1638 hrs
edical Examin		la. Facility Name (if not institution	-		- 4	b. City, Tov	vn, or Lo	cation of E		Coroary	4c. Cour	ity of Death	n
	Н	1 Mile off Williams Ro				Cumbe	rland				Allega	•	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	-	If Under 2 Hours	24Hrs. 8 Min.			YYY) 9. Bii Co	rthplace (State or Foreign ountry)
Director	1	235-98-6162	1X M 2 F	37	Yrs		Dayo	110010		5-16-	-1970		MD
*		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Locati	on	_						10d. Inside City Limits
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ryland a-f sh	황	10e. Street and Number	garry	Oun	ibe i i and	10f. Zip C	ode				10g. Citizen of	f What Cou	untry?
or 28	Director	14800 Barton l	Blvd.			2	1502	2		]	US	SA	_
with the 13 s 13 s 23 s e noti		11. Marital Status	12. Was De	cedent Ever in L	I.S. 13. Wa	s Decedent es, specify	of Hispa	anic Origin	? (Spec	ify Yes or N	o- 14. R	lace - Ame Vhite, etc.	rican Indian, Black,
death rr iter	Funeral	1 Never Married 2 X N	1 Yes	2 x No		_			deno i di	oan, cto.,	1		• .
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36 hin 72 e. than sdical	ם	12	4	,	Devel	oper							Develpoment
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218 be fill antal H urked	Be	Lawrence Kesse			Les Marie	A d dage =	(0)	Pa	tric	ia Go	odman umber, City or	Town Sta	te Zin Code)
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Important. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	}	Elissa Kessel  20a. Method of Disposition			Place of Dispos	sition (Name				Date	20c. Local	tion - City o	or Town, State
Ore ges 1 at of Ha : If it		1 X Burial 2 Crematic		from State	crematory or of tomac M		ordo	220	2-27	_2008	Kowa	cor	LTS7
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit			d										
Ox 68760, eath certificate be execute attending physician and for use as the burial - tra	edical	UNPENDED	AMENDE						_		23d D	ate of deliv	rery
6876C certificate Iding phys	n/M	IF FEMALE: 23b. Was decedent pregnant in	41	s, outcome of pro		etal death	3	Ectopic	pregnan	су	Mo		Day Year
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BOX he death c	Phys	Part II. Other significant cond	a [Oiii	nown	t resulting in the	underlying	cause g	iven in Pa	rt I.	23e. Di	d tobacco use	contribute	to the cause of death?
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Ospita hours ineral y fille		4 Homicide	Dharisian Tathal	fy) Woods	edge death occ	urred at the	time, da	ate and pla	ace, and	due to the o	ause(s) and n	nanner as s	stated.
Divisi To the Hospital or At within 24 hours after At To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical E	xaminer: On the bas and manne	is of examinatio	n and/or investig	ation, in my	opinior	, death oc	curred at	t the time, d	ate and place,	, and due t	o the cause(s)
To Wit	Me	29b. Signature and title of cert	ifier	s stated.		290	c. Licens	se number				-	(Month, Day, Year)
		2 1	1. 11				O.C.	M.E.			Febru	ary 24, 2	2008 
20		30. Name and address of pers	on who completed o	ause of death (I	tem 23a)	one Ctus	ot Dal	timore	MD 24	201			
MAS			eputy Chief Me			enn Stre	ei, Bal	ambre,	IVID ZT	201			
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		1	For State Registrar	State of Maryland	•	artment of F rtificate of			giene Reg. No.	2008	08640
1 m	4		Decedent's Name (First, Middle,	Last)				Date of Dea     Month	Day	Year	3. Time of Death
	sicia ledica		Mary Louise	Kent				Februa	ary 2	28, 2008	
Exa	amine	r	4a. Facility Name (If not institution, Warm Care Assi			4b. City, Town, o	r Location of Death		40.	County of Death  Mon tac	
Fune Direc	,			6. Sex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Feb. 19	v. Year)	9. Birth	place (State or Foreign intry) liana
pun		-	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
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the r	DOC	rec	10e. Street and Number	Hon egomery		10f. Zip Code	7C ONO DAG		10g. Citiz	zen of What Cou	untry?
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2 should and Men	matic	၉	19a. Informant's Name/Relationsh		19b. Maili	ng Address (Street	and Number or Rui			<u> </u>	lip Code)
and 2 s ealth an	er trau		J. Laurence Ken				ng Post La	ane, Noi	rth I	Bethesda	a, MD 20852
mit. Pages 1 apparament of He	iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( <i>Sp</i>	3 ☐ Removal from State	cemetery, cre	osition (Name of matory or other pla n Nat'l (	ce) Ma	Date arch 11		ington,	Town, State Virginia
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COIdS, P.O. BOX 06/00, w requires that the death certificate be executed been signed by the attending physician and	ched for us	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c	aldeath 3	□Ectopic pregnand □ Other (specify) _				Month	Day Year
ords, P.O. requires that the een signed by the	ld be deta	d by Phys	Part II. Other significant condition	ons contributing to death but not res	sulting in the u	underlying cause gi	ven in Part I.				the cause of death? obably 4 ☐ Unknown
The lar	age 2 sho	Completed								death?	utopsy findings available completion of cause of 2 No
VITAI ilcian: T	stor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea		-		
F SE	ਰ	고	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐		all DOX				6 ₺ Other (Spe	
Ing P Affert	uneral		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ıryat ork? ]Yes 2∐No	28d. Describe	how inju	ry occurred	Living
UIVISION C al or Attending P s after death. Il Director: After t	in by the	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 280 Place of injury . At h	ome, farm, s fy)			28f. Location ( City or To	(Street ar own, State	nd Number or Ru e)	ural Route Number,
DIVISION O  To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the	letely filled	Medical Ce	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best of my kno Examiner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	e cause(s , date an	s) and manner as ad place, and due	s stated. e to the cause(s)
To the To the To the	сошр	Me	29b. Signature and title of certifier		N	29c. Licer	se number			ate signed (Mont	
12			1 () Lole	It I Seu	- W >	s	D23556		Mar	ch 3, 20	008
			30. Name and address of person Robert Blee		consin	, Print) Avenue,	#1400, C	hevy Ch	ase,	MD 208	15
Re	Sta egistr		31. Date filed (Month, Day, Year)  MAR 0 4			W.					

Registrar DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** RICHARD 093 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner HACERSTOWN WASHINGTON If Under 24 Hrs. 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1⊠M 2□ F 83 103-18-3106 May 5, Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified a 1 □ Yes 2 NO Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18022 Putter Drive 21740 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify white þ 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aircraft mfg. aerospace engineer other traumatic event, 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Albert Lopez Marie Emelia Ferreira ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Lopez - daughter 18022 Putter Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 3/7/08 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC Physician Due to (or as a consequence of):

| Due to (or as a consequence of):

| Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events METASTATIC PROSTATIC CARCINOMA Division of Vital Records, P.O. Box 68760, resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco usa contributa to tha cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes No 1 Tes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 10 X Yes 2 □ No this nours after death.
nerel Director: After this
filled in by the funeral d 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 5 Pending investigation Natural Accident 1 ☐ Yes : ____No 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1120 PROPESSIONAR AMALFITANC 31. Date filed (Month R State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_			For State Registrar	State of Mary		tificate of		R	eg. No.	18	08642	
-	Physici	an	1. Decedent's Name (First, Middle, Last)  William S. Lindsey , Sr.  2. Date of Deat Month Februar								3. Time of Death 12:33 P M	
	/Medio		4a. Facility Name (If not institution, gir			4b. City, Town,	or Location of Death		4c. County of		12:33 P	
	- LAUIIIII		Baltimore Washi		al Center		Burnie			Aruno		
	Funeral Director		218-28-6949	Sex 7. Age (Ir	75 Yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day) Sep. 2	1932	9. Birthplac Country <b>Ma</b> 1	ce (State or Foreign y) ryland	
	land ow It		Usual Residence of Decedent  10a. State 10b. County	10	cation			10d	. Inside City Limits			
	a-f sh	ctor	MD Anne A	Arundel	Pasaden	a					1 ☐ Yes 2X No	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 882 Northfield Av		10f. Zip Code	-	g. Citizen of What Country?  USA					
	r dear	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. 1	Was Decedent of f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American , White, etc		
land 21215-0036	ours afte iral", or it Examin	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Korea			1□Yes 2█No	Specify:	Specify:	Specify: White			
	"natu	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)  College (1-4or 5+)	16a. Dece	lent's Usual Occu kind of work done DO NOT use retire	rking	16b. Kind of Business/Industry				
	withir iene. than	Completed	Elementary/Secondary (0-12)	ine.	Police			Law Enforcement				
	ild be filed lental Hygi ked other ic event, til	To Be C	17. Father's Name (First, Middle, Las William Colton	t)				ne (First, Middle, I n Gunther		?)		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship Deanna DiMarino/I				eld Avenu		r, City or Town, S dena, M			
Baltimore,	Pages 1 and of He Int: If Item		20a. Method of Disposition  1   Burial 2 □Cremation 3   4 □Donation 5 □ Other (Spec.	Themoval from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other pla ren Memo	_ LUCL	r. 6	20c. Location - C	•		
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	216		Name and Addr arranco d 5 Gov. I				-	eral Home 21146	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the rone cause on each line.  a. Due to (or as a co	death. Do not ent					A Ir	pproximate nterval Between Onset and Death 251 flan CM	
or Vital Records, P.O. Box 68760,	ifficate be executed g physician and as the burial-transit	Physician/Medical Examiner									(-=	Le sy
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date Mon	of delivery th D	ay Year	
	uires that the de signed by the a d be detached to	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							co use contribute to the cause of death?		
	yysician: The law requires that the death cer is certificate has been signed by the attendin director, page 2 should be detached for use	Completed						24a. Was a autops perfor	med? pi	rior to comp eath?	y findings available pletion of cause of	
		Be (	25. Was case referred to medical examiner?	11		10		ath (Check only on	ne)			
	ys dir	မ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpatier 28b. Time o	I JODON			ence 6 Othe	te 6 Other (Specify)		
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Datural 5 Pending (Month, Day Year) 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury 28b. Time of Injury Work? 28b. Time of Injury 4 Work? 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in 1 Yes 2 No 28d. Describe how in							et and Number or Rural Route Number,		
			29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch									
	the H hin 24 the F	Medical	one) and manner stated.									
	\$ \$ \$ \$	1	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)  Charles W MS (Ste, Ibb., Glenburn, e.m.) 32. Degistrar's Signature  MAR 0 3 2008  MAR 0 3 2008									
	W.	V	30. Name and addless of person who	completed cause of death	(Item 23a) (Type,	Print) Why Hus.	Stein	h Glen	Burn +	ms	2(06)	
	Sta		31. Date filed (Month, Day, Year)	32. Pegistrar's	Signature		3	-)	770	1	3	
DH	Registi		MAR 0 3 2	1000 Plane	B A	nouse!						

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner

P.O. Box 68760.

Division or Vital Records,

Pages

with the Maryland

death

filed within 72 hours after

al Hygiene.

is marked ot 1 and 2 should be

altimore, Maryland 21215-0036

show

Completed Be

and burial-tra physician the for signed k director, after death filled in by 24 hours a Funeral I the To the

The law requires that the death certificate be executed Hospital or Attending Physician:

Certification: To

Medical

15+ IVA State

25. Was case referred to medical examiner? Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2 No

24a. Was an autopsy performe

21921

24b. Were autopsy findings available prior to completion of cause of death?

2007

1 ☐ Yes 2 ☐ No

K-1. Neywo D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Narayana Rao V. Pula, M.D., 118 North St., Elkton, MD

and manner stated.

31. Date filed (Month, Day, Year) MAR 0 5 2008

29b. Signature and title of certifier

Registrar

29c. License number

D0069733

	For State	State of Iviar	-	eparime C <i>ertifica</i>			Mental Hy		2008	naah	
	Registrar  1. Decedent's Name (First, Middle, Las	(t)		Jerunca	ile OI L		2. Date of De	Reg. No.	6000	3. Time of Death	
n	Sherman Os						Month Februa	Day	9, 2008	9:14 p \	
il r	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				County of Deat		
¥.	Golden Living Center				Westminster If Under 1 Year   If Under 24 Hrs.   8, Date of Birth					coll	
To Be Completed by Funeral Director	5. Social Security Number  220-26-6052  Usual Residence of Decedent  6. Sex  1 M 2 F 7. Age (In yrs. last birthday, 85 Yrs.				s Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar 14	v. Year)	(70	hplace (State or Foreig untry) Tyland	
	10a. State 10b. County Maryland Carrol		Ioc. City, Town	or Location	Ta	aneytown				10d. Inside City Limit	
	10e. Street and Number 31 George Street				10f. Zip Code 21787				0g. Citizen of What Country? USA		
	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?			13. Was Dec	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give T.W.TTT			1 □ Yes 2 No Specify:			Specify: white			
	(Specify only highest grade completed) (Giv			Give kind of v	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)			16b. Kind of Business/Industry			
	8	Elementary/Secondary (0-12) College (1-4or 5+)			Arborist				ree Bus	siness	
	17. Father's Name ( <i>First, Middle, Last</i> ) Oscar H. Lewis				18. Mother's Name (First, Middle, Maiden Surname)  Ada A. Draper						
	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Shannon Lewis White, niece  4330 Sam's Creek Road, New Windsor, MD 21776										
	1 M Purial 2 Cramation 2 D Pamayal from State cemetery, crematory or other place)								c. Location - City or Town, State Caneytown, MD		
	21. Signiture of Funeral Service Licensee 22. Name and Address of Facility Myers—Durboraw Funeral Home 136 E. Baltimore Street, Taneytown, MD 21787										
	23a. Part I. Enter the disease, or comp shod, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the cause of the cause on each line a.  Due to (or as a	letas	afu	1	g, such as cardiac		rrest,		Approximate Interval Between Onset and Death	
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Dise to (or as a consequence of):  c. Due to (or as a consequence of):										
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							2	23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					n in Part I.		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unkno			
þ									.00 Upages		
ò								psy prmed2/	prior to death?	completion of cause of	
Completed by	25. Was case referred to medical					26. Place of Dea	auto perfo 1⊟ Yes	psy ormed? 2 No	prior to o	utopsy findings availab completion of cause of 2	
o Be Completed by	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient				r: 4 Nursing H	auto perfu 1 □ Yes th (Check only one 5 □ Resi	psy prmed2 2 No one) dence 6	prior to death? 1 □ Yes	2 146	
To Be Completed by	examiner?	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of jury	28c. Injury Work 1 🗆 \	r: 4 Nursing H	auto perficience in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	psy primed 2 2 No one) dence 6 how injury	prior to death? 1 Yes  5 Other (Specty occurred)	2 146	
o Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Sulcide 4 Homicide  29a. Certifier  1 Certifying Ph	28a. Date of Injury (Month, Day)	Year) 28b. Ti In y - At home, fan (Specify) my knowledge, examination and	me of jury M m, street, factored death occurred	28c. Injury Work 1 🗀 \	er: 4 □ Nursing H rat rat rat res 2 □ No	auto perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfection of the perfect	psy primed 2 2 No 2 No 2 No 2 No 2 No 2 No 3 No 4 No 4 No 4 No 4 No 4 No 4 No 4 No 4	prior to death? 1 Yes  6 Other (Spectrum of Number or Rumanner as	completion of cause of 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

State Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 2008

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland		tificate of I		,	Reg. No. 201	38	08645
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of Death
4	/Medic	al	GENEVIEVE ARBUTUS LOHR  4a. Facility Name (If not institution, give street and number)		4h City Town or	Location of Death	FEBRUAF	4c. County o		9:20 P.M
	Examin	er	NEW HOPE PERSONAL CARE HOME		CUMBER			ALLEC		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Age (In yrs. las 100	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da FEB• 2	y, Year) 3,1907	Cour	place (State or Foreign ntry) YLAND
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, 7	Town or Loc	ation				1	10d. Inside City Limits
	Mary a-f sh ified a	ctor	MD ALLEGANY CUM	MBERLA	ND					1 XYes 2 No
	n with the	al Dire	10e. Street and Number 135 N. MECHANIC STREET		10f. Zip Code 21502			10g. Citizen of W		itry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Pueric Specify:	pecify Yes or No Bican, etc.)	14. Race Black Specify:	, White,	ean Indian, etc.
21215-0036	hin 72 ho e. an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give k life. D	O NOT use retired	during most of work	king	16b. Kind of Bus	iness/Ind	dustry
	ed wit ygiene ner tha	Con	9	HOM	IEMAKER		(F) 1 N ( )	HOME	,	
Maryland	d be fill hard He ed oth	Be	17. Father's Name (First, Middle, Last) HARMON FREDERICK HINZE				e (First, Middle, ARGARET	Maiden Surname HERING	y	
Ž	should nd Me mark imatic	은		19b. Mailing	g Address (Street	and Number or Ru			State, Zir	Code)
	and 2 saith an 27 is		JACQUELINE COCKEY / DAU.	1018	BOWSPRIT	LANE, H	OLIDAY,	FL 346	91	
Baltimore,	Pages 1 ament of He ant: If item ury or oth		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, crem	sition (Name of natory or other place <b>CEMETE</b>	ce)	Date 9/2008	20c. Location - CUMBE	-	own, State
Balt	permit. Departimontany inj		21. Signature of Funeral Stryla Literatee	22.	Name and Addres UPCHURCH 202 GREE	ss of Facility I FUNERAL INE STREE	HOME, I	P.A. ERLAND, 1	MD	21502
	Physician	(1 )	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition esulting in death)		er the mode of dyin		or respiratory a		Ţ	Approximate Interval Between Onset and Death TEW YEAR S
	/Medical Examiner		Due to (or as a consequer	Men	DISEAS	515				
	ted sit	nine	Sequentially list conditions, if any, leading to minieurate cause. Enter Underlying Cause (Disease or injury that initiated events	moe ut).						
68760,	tificate be executed ig physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last	ince of):						
687	ifficate g phys as the	edical	d	(a)				- 15		53
P.O. Box	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal di 4 □ Pregnant at time of deal	death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date Mon		ery Day Year
	w requires that to been signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting	ing in the un	derlying cause giv	en in Part I.	23e. Did to			he cause of death?
Vital Records,	The law recate has bee page 2 shou	Completed	£			<del></del>	24a. Was autor perfo	rmed? p	rior to co eath?	opsy findings available impletion of cause of
ita I		BeC	25. Was case referred to medical examiner?			26. Place of Dea		ne)		
on or V	di is	ပို	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ EF  27. Manner of Death 1 ☒ Natural 5 ☐ Pending ☐ 28a. Date of Injury (Month, Day Year) ☐ 29	R/Outpatient 28b. Time of Injury	28c. Injur Wor	4 Li Nursing H	ome 5 Resident	dence 6X10the		onal Care W Home
Division or	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	ne, farm, stre			28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rura	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical C	29a. Certifier (Check only one)  1 XCertifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the til restigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	ner as s ind due t	itated. o the cause(s)
	To the within 2 To the To the CA complet	Me	29b. Signature and title of Schiller ws		29c. Licens	e number Y17 (Man	(cms)	29d. Date signed	(Month,	Day, Year)
•	nes		30. Name and address of person who completed cause of death (Item 2)	23a) (Type, F	Print)	-IPWAY	LAVALO	= MANY	·cm	5, 2008 10 21372
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 6 2008 32 Registrar's Signatur	ire	will.			•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death a.k.a. Day 2008 **Physician** MARCH 11, PETER  $\mathbf{E}$ LAPSA Peteris Eduards Lapsa 10:35A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Feb 26, 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 282-36-7711 1**X**) M 2□ F 97 Lithuania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Frederick 1 ☐ Yes 2 X No Adamstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3200 Baker Circle 21710 U.S.A. Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 XXIIII on If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 1 No Specify Š 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Medical Doctor College (1-4or 5+) Elementary/Secondary (0-12) Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martins Lapsa Karline ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas Lapsa, Son 1860 Mt Ephriam Rd, Adamstown, Maryland 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Mar 14, 2008 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Dicensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M00706 106 East Church St. Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

attending physician ō the ò peen hasl page 2 certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice the

requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

and

death with the Maryland

Baltimore, Maryland 21215-0036

filled in by

29a. Certifier (Check only one)

29b. Signature and title of certifier

4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lar uova

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number

D65443

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elena Iarikova, M.D., 400 West Seventh Street, Frederick, Maryland 21701

State Registrar

Medical

31. Date filed (Month, Day, Year) 8



DHMH 17 Rev 1/2001

within 24 hours a

To the

			1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	23c,25 per me,g	877	1913617699	<b>Stat</b> th	2. Date of De	9	108	08647
	Physici		JOAN F. LEWIS					Month MARCH	3, ^{Day} 2008	Year	4:30 P M
)	/Medic Examin		4a. Facility Name (If not institution, give s. 5135 70TH PLACE	treet and number)		4b. City, Town, or HYATTSV	Location of Death			ty of Death	RGES
·	Funeral Director		5/8-58-4826	M 2∏F 7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 9/26/1	th <i>Year)</i> 943	9. Birthp Coun SOUT	lace (State or Foreign try) H CAROLINA
	land ow at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	vn or Loc	ation				1	0d. Inside City Limits
	a-f sh	ctor	MD PRINCE G	EORGES HYATTS	SVILI	ĿΕ					Y∏Yes 2 No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o USA	f What Coun	itry?
30	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	5135 70TH PLACE  11. Marital Status  1 ★ Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates:		37	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. R	ace - Americ ack, White, city: BLA	etc.
215-0036	within 72 hou ene. than "natura he Medical E)	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 16a	(Give k life. D	ent's Usual Occup ind of work done of O NOT use retired CLERK	durina most of work	ing	16b. Kind of		dustry
Z	filed w Hygier other th	Cor	12TH 17. Father's Name (First, Middle, Last)		DI OI	CLEKK	18. Mother's Name	e (First, Middle,			
land	Ald be fental rked o	To Be	JAMES LEWIS				GRACE GI			·	
Mary	s 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type THERESA LEWIS/DAUG	· ·	,	•	and Number or Run				Code)
a)	1 and Health tem 27		20a. Method of Disposition			ition (Name of atory or other place	CE HYATTS	Date	20c. Location		own, State
Ē	g = 5		1∑ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other ( <i>Specify</i> )	moval nom State			ERY 03/08	3/2008	BRENTW	00D, N	<b>1</b> D
Baltimor	permit. Par Departmen Important: any Injury		21. Signature of Funeral Service License		22.	Name and Addres	ss of Facility J.B VER ROAD	. JENKI	INS FUN	ERAL F	
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do e cause on each line.	not ente	r the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	GLIOSARCOMA  Due to (or as a consequence	of):				11	1	
	Examiner		h	PARAPLEGIA	, OI).	-		^	///		
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence			-	-/-			
08/00,	tificate be executed g physician and as the burial-transit	sal Examiner	that initiated events resulting in death) Last	Metastatic Sai		a to the		Spine/	NEX BY WEDICH	EXAMIN	
	rtificate ng phy as the	Medical	IE EEMALE.				OFF.	/			
	w requires that the death cer been signed by the attendin should be detached for use	Physiclan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	8c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deatt 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other <i>(specify)</i>	/			Date of delive Month	ery Day Year
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ecords	requires een sign							1 🗆	1111		pably 4 □Unknown
Lec	a & S	ompleted						24a. Was auto	an 24 psy ormed?	<ul> <li>b. Were auto prior to co death?</li> </ul>	psy findings available mpletion of cause of
N Ear		O	25. Was case referred to medical				26. Place of Deat	1□ Yes	2 No		2 No
20	> .∞ p	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient		er: 4 Nursing Ho			Other (Specif	fy)
=	ffel ne		27. Manner of Death  1   Natural 5   Pending  2   Accident investigation		Time of Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2 □ No	28d. Describe	how injury occ	urred	
DIVISION	I or Attending after death. I Director: After is in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At home, fi building, etc. (Specify)	arm, stre		760 2 110		(Street and Num wn, State)	mber or Rura	al Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 2 Medical Examin	iclan: To the best of my knowledg er: On the basis of examination a and manner stated.	je, death nd/or inv	occurred at the tir estigation, in my o	me, date and place, ppinion, death occur	and due to the rred at the time	cause(s) and , date and plac	manner as s e, and due t	stated. o the cause(s)
)	To the within To the comp.	M	29b. Signature and title of certifier			29c. Licens	e number 7380		3/6/0	ned (Month,	Day, Year)
			30. Name and address of person who con			Print)		0.000			
	× Sta		R. SAMUEL MAYER M. I	D. 600 N. WOLFE  32. Registrar's Stanature	STR	EET BALT	LMORE, MD	21287			

Registrar

			For	State of Maryland				Mental Hyg	iene	
			State Registrar		Cer	tificate of l	Death		eg. No. 2 1 1 8	08648
4	Physicia	20	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
No. of	/Medic		Walter McCummin	igs				March 1		144/ M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	1	4c. County of Death	
10 A			3501 Halloway Nor			Upper M			Prince C	
П	Funeral		5. Social Security Number 6. Sex		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCt. 31	Year) 0.10 C Cou	place (State or Foreign arolina
	Director		247-82-3176 Usual Residence of Decedent	^{™ 2□ F} 59	113.			000. 31	, 1940 5.	aloma
	and		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	Mary f sho ied a	0	MD Prince Ge	orge's Upp	er Mar	lboro				1 ☐ Yes 2 No
	the 728a	Director	10e. Street and Number	orge o pp.		10f. Zip Code		10	0g. Citizen of What Cou	ntry?
	3a o		3501 Halloway Nor	-th		20772			USA	
	ms 2	Funeral		12. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - Ameri Black, White,	
9	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be nuffiled at		1 ☐ Never Married 2 Married	1 XYes 2 No		i res, specify Cube	Specify:	o moan, etc.)	0	
93	ours iral", Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1966–8	86				DTC	
5	72 h "natu dical	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	rking	16b. Kind of Business/Ir	dustry
2	vithin han e Me	шb	Elementary/Secondary (0-12)	College (1-4or 5+)		er Sergea:	•		US Air Ford	ce
S	iled v Hygie ther t		17. Father's Name (First, Middle, Last)		rasce	J Dergea		ne (First, Middle, I		
and	t be f ntal F ed ot	Be	Charlie McCumming	ıs				ed Alford	•	
Ž	hould d Me mark matic	P.	19a. Informant's Name/Relationship (Type	<u> </u>	19h Mailin	n Address (Street	and Number or Bu	ıral Boute Number	; City or Town, State, Zi	o Code)
Maryland 21215-0036	id 2 s th an th an traul		Diane J. McCummir		i	Halloway			arlboro, MD	20772
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be natified at once.		20a. Method of Disposition		ace of Dispo	sition (Name of natory or other place		Date	20c. Location - City or T	own, State
<u>o</u>	ages ent of t: If if		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	metery, cren	Veteran'	g c 3/1	0/2008 0	Cheltenham,	MD
Baltimore,	artme ortan injur		21. Signature of Funeral Service License	ee   rial	22	. Name and Addre	ss of Facility Be	all Funei		
Ã	Dep Imp any onc	0. 7	12683	<del>}</del> 0		512 NW C			ie, MD 207	15
r.	78		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory arm	est,	Approximate Interval Between
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1	/Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	c . Jper	101311			
	Examiner		Convention list conditions							
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dus to (or as a conseque	ence of):				- 1	
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Вох	attendation of the contraction o	ian	in the past 12 months?	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)	/		Month	Day Year
<u>Р</u> .	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	all 3L					
σ.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:		Part II. Other significant conditions cor	ntributing to death but not resul	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Sp.	uires sign ld be	d by	Diabetes					1 🗆 Y	es 2∐No 3∏Pro	bably 4 Unknown
00	w req beer shou	Completed						24a. Was a	n 24b. Were aut	opsy findings available
Re	he lav e has ige 2	m d						autops perfor	med? death?	opsy findings available ompletion of cause of
ā	ician: Th certificate ector, pag		25. Was case referred to medical				26 Place of De	1  Yes ath <i>(Check only</i> on	2 No 1 □ Yes	2□ No
>	ysicia is cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	t 3 DOA Oth	or		ence 6 □Other (Spec	ifv)
Division or Vital Records,	g Phy er thi eral o	n:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor			ow injury occurred	
0	nding F ath. r: After re funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Indital, Day Year)	injury		Yes 2 □ No			
<u>                                      </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (S. City or Tow.	treet and Number or Ru n, State)	ral Route Number,
	italo rs aft ral Di led in	Cer								
	Hospital or Atteno 4 hours after death Funeral Director: tely filled in by the	edical	(Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati						
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medi	one)	and manner stated.		29c. Licens	e number		29d. Date signed (Month	Day Year)
	To wit		29b. Signature and title of certifier	1151-7-		Hm.	550	7	110 00 100 100 100 100 100 100 100 100	2-208
	15)		Marian /	Lyre vo	\ '-	1 200	· 37 72	/ /	yaren T	-000
96	pC.		30. Name and address of person who co	Ter 3001 H	23a) (Type,	Ed Dain	e Cha	ed 1	March 4, say land	
(1)	Sta	to		32. Revistrar's	SER 1	27100	1	01	7 -0(	
	Sta Registr		MAR 0 5 2008 (Martin MAR)	en fr 17	h-mill					

			1 - For State Registrar	State Of Ma	-	epartment of Certificate of	Health and M f Death	ental H	ygiene Reg. No.	the the the	08649
12			Decedent's Name (First, Middle, La	st)	• •			2. Date of D			3. Time of Death
	Physici /Medic		CHARLE	S IV	IAX	WELL		Month 2	22	08	10:30 01
	Examin	er	4a. Facility Name (If not institution, giv	e street and number) EALTH	ORFL	4b. City, Town,	or Location of Death	@1177	4c.	County of Death	
-	Funeral		5. Social Security Number 6. S	ex, 7. Age	(In yrs. last birt			8. Date of B	irth	9. Birth	place (State or Foreign intry)
ı	Director		11-01-000	ØM 20F	92	rs. Months Day	s Hours Min.	10-14	-15		his, Tn
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	e Mar	Director	Maryland Montgome	у	Silver	Spring					1 Yes 2 □ No
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Modical Examinations is not be notified at		10e. Street and Number			10f. Zip Code				zen of What Cou	·
	death ms 23	Funeral	901 Arcola Ave.	12. Was Decedent B	ever in U.S.	2090:	2 Hispanic Origin? (Spe ban, Mexican, Puerto I	cify Yes or N		ed State  14. Race - Amer	ican Indian,
	or ite		1 Never Married 2 Married	Armed Forces? 1 1 Yes 2 □ N If Yes, Give	o	If Yes, specify Cu		Rican, etc.)	1	Black, White	
hours	lurai', al Exe	d by	3 Widowed 4 Divorced	Year or Dates:	1.40-					Specify: Blad	
within 72 hours after death with the Maryland	n na Medic	piete	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Usual Occi (Give kind of work don life. DO NOT use retir	e during most of working	ng	160. Kil	nd of Business/li	ndustry
ad with	t, the	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		il Room Suj	pervisor		Gov	ernment	
be file	event	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	•	e, Maiden	Sumame)	
plnous	marke marke	은	Cornell Maxwell  19a. Informant's Name/Relationship (	Tyne Print)	19h	Mailing Address (Street	Nancy Whi		her City or	r Town State 7	n Code)
nd 2 s	27 is			ife		6 2nd Stre		Ington		. 20011	<i>p</i> 0000)
Φ.	or Hei		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of	Disposition (Name of crematory or other pl	D	ate		cation - City or T	own, State
permit. Pages Department of I	jury o		`4 □ Donation 5 □ Other (Specify	<i>'</i> )	Quanti	co Nationa	1 3/5/20	208	Tris	ingle, V	8
permit.	Department of Important: If it any injury or once.		21. Signature of Funeral Service Licen	D H		22. Name and Add	ress of Facility Pope	Funer	al Ho	omes, P.	Α.
T			23a. Pert1. Enter the disease, or compshock, or heart failure. List only	olications that caused	the death. Do n	5538 Mar1 of enter the mode of dy	boro Pike I	Forest respiratory	ville arrest,	, Maryl	Approximate
Phv	sician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line A D The			ANDIONASC		A	CA CIC	Interval Between Onset and Death
	Medical aminer		resulting in death)	Due to (or as a	consequence		KILDIONITAL	VUIL	136	5/17.0	Y 5 THIS
LAU	IIIIICI	-	Sequentially list conditions, if any, leading to infriedrate	b. — Que to for as a	consequence o	n					
nted	d ansit	miner	cause. Enter Underlying Cause (Disease or injury that initiated events	220 10 (01 40 4		'7'					
э өхөс	ian an irial-tr	Exa	resulting in death) Last	Due to (or as a	consequence o	f):					<del></del>
The law requires that the death certificate be exec	attending physician and for use as the burial-transit	Completed by Physiclan/Medical		d							
certific	ISB as	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				2	23d. Date of deliv	an/
death	e atter	iclar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 ☐ Ectopic pregnant 5 ☐ Other (specify)				Month	Day Year
at the	f by th	Phys	9 Unknown	9□ Unknown							
ires th	been signed by the s should be detached	by	Part II. Other significent conditions of DEMENTA.	-	-		iven in Part I.			1	the cause of death? bably 4 Dunknown
w requ	shouk	etec	MALNUTRINO		-C , / /	-/1/2///		24a. Wa:			
The la	age 2	ошо	1/1/2/10/1-1/10	70.				auto perf	opsy ormed?	prior to co death?	opsy findings available ompletion of cause of
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	ctor. p	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes	2.⊒No one	1 ☐ Yes	2 LI NO
Attending Physician: r death.	this ce al direc	2	1 ☐ Yes 2 ☐ No	1	t 2 ER/Out	DATIGHT 3 DOA	ther: Varsing Hom	ne 5□Res	idence 6	S □Other (Speci	fy)
ding F	Atter	ilon:	27. Manner of Death  Natural 5 ☐ Pending  Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Ti	ury Wo	uryat 2 ork? ]Yes 2 ☐No	8d. Describe	how injury	y occurred	
Atten r deat	oy the	flca	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, fan	n, street, factory, office		8f. Location	(Street and	d Number or Run	al Route Number,
s afte	ed in t	Certification;	4  Homicide determined	building, etc.	(Specify)			City or To	wn, State)	)	
Hospital	Funer lely fill	Medical	(Check only 2 Medical Exam	iner: On the basis of e	examination and	death occurred at the for investigation, in my	ime, date and place, a opinion, death occurre	nd due to the	cause(s)	and manner as s	stated. o the cause(s)
To the within 2	complitely filled in by the funeral director, page	Med	one) 29b. Signature an Little of certifier	and manner state	ed.		se number		Maria Contraction	e signed (Month,	
¥ ∓	F 8		1. Smans	moon		05	3367	- 3		2/25/	
	(6)		30. Name and address of person who o	completed cause of de	ath (Item 23a) (T		,	AL RI			
	10		980 GEON 12	ANEWAR IN	11 (F:11)	JICHALLE	HYAMIUN ND	: 207	02		
	Stat Registra		31. Date filed (Month, Day, Year) MAR 0 5 2008	32. Registrar	s signature	•					
4		- E-	130	WAY IS	A CONTRACTOR OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF TH						

			State Amend 25, 27, 28	State of Ma Ba-f per ME g878	aryland / Depa 3 4/15/08 <b>gra</b>	artment of H <i>rtificate of L</i>	ealth and N Death		giene Reg. No. 2008	08650
	Physicia	_	Decedent's Name (First, Middle     HOWARD	e, Last) MANNING				2. Date of Dea Month 2	Day 2008	3. Time of Death 4: 28 P. M
1	/Medic Examin		4a. Facility Name (If not institution	, give street and number)			Location of Death		4c. County of Dea	th
		100	WMHS MEMORIAL			CUMBERLA	AND	T	ALLEGANY	
	Funeral Director		5. Social Security Number 217-30-1849	6. Sex 7. Age 1 X M 2 □ F	73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	JULY	ALLEGANY h Year) 7,1934 M	thplace (State or Foreign ountry) ARYLAND
	fand ow tt		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary I-f shi fied a	tor	WV MIN	ERAL	RIDGELEY	Y				1 □Yes 2 No
	th the or 28¢	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath wii 23a c ust b	la l	ROUTE 4, BOX	185-G		26753			U.S.A.	
စ္	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mential Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status 1 □ Never Married 2 Marr	If Yes Give	lo	Was Decedent of Hi f Yes, specify Cuba 1 □ Y <i>e</i> s 2 <b>X</b> No		ecify Yes or No Rican, etc.)	Chaoifu	te, etc.
Maryland 21215-0036	hours ural",	d by	3 Widowed 4 Divorced	Year or Dates:	'52- <u>'</u> 55				16b. Kind of Business	HITE
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212	yiene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	CHINIST			GLASS	
bu	be filed vital Hygie d other i	Be C	17. Father's Name (First, Middle,						Maiden Surname)	
ylaı	should be ind Mental marked umatic ev	2	JOHN WESLEY M	ANNING				A MAE LA		
Jar	12 sho h and r Is m raum		19a. Informant's Name/Relations			. ,			er, City or Town, State,	
e, 1	1 and: Health em 27		BETTY LEE UTZ  20a. Method of Disposition	MAINIVING / W.	20b. Place of Dispo	FE 4, BOX sition (Name of		Date Date	Y, WV 2675	
JOL.	Pages nent of t ant: If ite		1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (S			natory or other plac ND CREMAT		4/08	CUMBERLA	ND, MD
Baltimore,	permit, Pag Department Important: It any injury o		21. Signature of Funeral Service		22	2. Name and Addres	s of Facility		P.A. ERLAND, MD	
		-	23a. Part1. Enter the disease, or	complications that caused	the death. Do not ente					21502 Approximate
	Physician	1	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)		SEPSIS WIT	TH ENDOCA	RDITIS			Interval Between Onset and Death
6	/Medical Examiner		resulting in deality		a consequence of): CANCER WITH	H SMALL B	OWEL OBSI	TRUCTION	I	
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68760,	ficate be executed physician and s the burial-transit	edical		d						
			IF FEMALE:	23c. If yes, outcome	pf pregnancy				23d. Date of de	divery
Box .	death certif e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
P.0	that the de hed by the a	hys	9 ☐ Unknown	9LlUnknown						
or Vital Records, F	The law requires that the tte has been signed by the bage 2 should be detache	þ	Part II. Other significant condition CACHEXIA, ATRI	ons contributing to death bu ALFIBRILLATIO	ut not resulting in the up DN, COPD, I	PNEUMONTA	en in Part I.	23e. Did to	obacco use contribute t Yes 2 □ No 3 □ F	
000	ne law rei has bee ye 2 shoi	Completed	ILEOSTOMY, HIP					24a. Was		utopsy findings available completion of cause of
Ä		Com	DEHYDRATION, H	YPOTENSION SI	ECONDARY TO	O DEHYDRA	TION	perfo	ormed? death?	s 2□No
/ita	ysician: This certificate	Be (	25. Was case referred to medica examiner?			Oth	26. Place of Deat	th (Check only o	one)	
or \	di Si	2	1 Yes 2 No 27. Man Death	Hospital: 1 Impaties 28a. Date of Injur	nt 2 ER/Outpatien  28b. Time of		4 LI Nursing H		dence 6 Other (Sp	ecify)
	ding h. After	tion	5 ☐ Pendin 2 Accident investig	g (Month, Day		Worl	k? Yes 2. ∐ANo			
Division	Attending r death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could determ	not be	iry - At home, farm, str	eet, factory, office		Subject f	Street and Number or F	Rural Route Number,
Ö	tal or s afte al Dir ed in	Cert	4	Nursing Ho		<u></u>		Cumberlar	nd, MD	ristie Rd.,NE
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (		ig Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in					
	To th To th comp	Me	29b. Signature and title of certifie	n lane	am.	29c, License	number 1769		29d. Date signed (Mor	19, Day, Year) 2009
	7/1VA		30. Name and address of person	who completed cause of de	eath (Item 23a) (Type,	Print/ P/E/	nonin	HO	SPITTAL	
	nds		THITESA	who completed cause of de	MP CL	MIBE	RLAN	0,1	70 21	502
	Sta Registr		FEB 2 6 2	008 Pagistra	ar's Signature	Es				

State Registrar DHMH 17 Rev 1/2001 1475

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Tanke

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31. Date filed (Month, Day, (ea)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ne

32. Registrar's Signature

**ORIGINAL** 

MO51610

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### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 02 21 2008 Miller Alice Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-Braddock Campus Cumberland If Under 1 Year If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 X F Director 213-22-4395 12-14-1926 81 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director PABedford Hyndman 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 128 Fifth Ave. Apt 214 15545 USAFuneral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic evonce. Otis Vernon Waltman Grace V. Buchanan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Miller/ Son 1278 Hyndman Rd., Hyndman, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 2-25-2008| Hyndman, PA Cooks Mills Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harvey H. Zeigler Funeral 21. Signature of Funeral Service License Home, 169 Clarence St. Hyndman 23a. Part1. Efter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-tran ed by the a detached f Medical Certification: To Be Completed by

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, tate has been signed page 2 should be det funeral dir ours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral I

completely filled

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	f heart 1	alling	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		oic pregnancy or (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underlyi	ing cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Hyper	tension		1 ☐ Yes	2 No 3 Probably 4 Unknown
Hype	Nipidemia		24a. Was an autopsy performed?	
25. Was case referred to medical examiner?			th (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐	□ DOA Other: 4 □ Nursing H	ome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	ysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month, Day, Year)
> Inaxo	ia MD	D006655	54 2	2/22/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1715

MD

10d. Inside City Limits

1 Yes 2 No

PA 15545

Smont

Registrar DHMH 17 Rev 1/2001

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State

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200832. Registrar's Signature

2 Seton Par, Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amended #8, nls, per fh, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 02/25/08, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mortebruary 21, 2008 Year **Physician** 12:15 AM M Michael Terry McAteer Jr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Frostburg 105 Armstrong Avenue 8. Date of Birth (Month Day, Ye October 20, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Maryland 1X M 2□ F 219-52-0476 59 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Frostburg Maryland Allegany Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 21532-105 Armstrong Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entrance Greeter Walmart alth and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael T McAteer Sr. Effie L. Raley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21532-Maryland Frostburg Tamara Filer-McAteer 105 Armstrong Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State February 25, 2008 Frostburg Maryland Saint Michael's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiomyopar **Physician** 2 years /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown icate has been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA

Division or Vital Records, P.O. After this certificate or Attending Physician: funeral director, s after dea. ral Director: After filled in by

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a

To the Funeral C

completely filled 7/4 nes

To the Hospital

29c. License number DO055325

29d. Date signed (Month, Day, Year) 2008

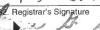
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

WALSH AD CUMBERLAND WONSOCK SHIN MD 925 BISHOP

State Registrar 31. Date filed (Month, Day, Year) FEB 2 2 2008

29b. Signature and title of certifier



			= For State Amend Ite	State of Ma ens 25,27,28	aryland / Dej Ba-f per C	partment of the 1887 er tilicate of	Health and I 3/14/08dh	Mental Hy	giene Reg. No.	2000	0.00051
	Physici		1. Decedent's Name (First, Middle, Flora Pauline					2. Date of D Month March	Day	708 Year	3. Time of Death 2:45 P. M
	/Medio Examir	45300	4a. Facility Name (If not institution, 14625 Barkdoll				or Location of Death	)	4c.	County of Dea	
	Funeral Director	**	5. Social Security Number 275–36–7589		e (In yrs. last birthda 95 Yrs.		r If Under 24 Hrs.	8. Date of B (Month, D	ay, Year)	9. Bir	thplace (State or Foreign buntry) st Virginia
	Maryland a-f show ified at	ctor	Usual Residence of Decedent           10a. State         10b. County           Md •         Was1	nington	10c. City, Town or	Location gerstown					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3a or 28 t be not	I Dire	10e. Street and Number  14625 Barkdoll			10f. Zip Code	1742		10g. Citi	izen of What Co	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1		I 3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S lban, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	lo-	14. Race - Ame Black, White Specify:	
21215-0036	nin 72 hours e. In "natural" Medical Ex	Completed b	15. Decedent's (Specify only highest  Elementary/Secondary (0-12)	Education	(Gi	cedent's Usual Occ ve kind of work don b. DO NOT use reti	e durina most of wor	king	16b. Ki	ind of Business	/Industry
	filed with Hygiene ther tha		11 17. Father's Name (First, Middle, La			Homem	18. Mother's Nan	ne (First, Middi	le, Maiden		ome
Maryland	nould be a Mental narked o	To Be	Frank L. We	elty	10h Mc	ulling Address (Stra	Berti	ha Iren			Zin Code)
	and 2 shealth and 1 27 is neer traun		19a. Informant's Name/Relationship Faith P. Porter		1462	27 Barkdo.	ll Rd. Hag	gerstow.	n,Md.	21742	
Baltimore,	Pages 1 in the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the sectio		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		Į.	position (Name of rematory or other p d Cemete.	Mari	Date Ch 7, 08		cation - City or	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Li	Davis A	101414	22. Name and Add	ress of Facility is Funera.	l Home	12525 Smith	Bradbunsburg,	ıry Ave. Md.21783
	Physician	/	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	omplications that caused nly one cause on each li	the death. Do not one.	enter the mode of d		•			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)		a consequence of):		^	11	1	A IPP	who TITUS
	uted 1 ansit	Examiner	Sequentially list conditions, and to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of):				BY MEDI	CAL EXAMITES	
8760,	ate be executed hysician and the burial-transit	ical	resulting in death) Last	Due to (or as	a consequence of):		"CERTIF"	ATI DI WILL			
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transiti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∐Pregnant a 9 ∐Unknown	2 Fetal death	3□Ectopic pregnal 5□ Other <i>(specify)</i>				23d. Date of de Month	Day Year
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Records,	9 - P	Completed	Froitu	ne, ne	ght he	P		24a. Wa au pe 1 Yes	topsy rformed?	prior to death?	
Vital	siclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	out OFFROntes	Nant 2000	26. Place of De.		_	o Flort (0-	
0	ding 7. After fune	tion: To	1 XYes 2 10 27. Mann Death  1 1 2 XAccident investigs	28a. Date of Inju (Month, Da		e of 28c. In	4 Li Nursing r	28d. Describ	e how inju		over chair ar
Division	or Atten ifter deat Director: in by the	Certification:	3 Suicide 6 Could no determin	ot be 28e. Place of ini	ury - At home, farm, c. (Specify)	-		28f. Location	(Street a	nd Number or F e) <b>1462</b> 5	Burkdoll Ro
_	Hospital 24 hours a Funeral stely filled	Medical C		Physician: To the best xaminer: On the basis of and manner st	f examination and/o			e, and due to the	ne cause(s	s) and manner a	
	To the within 2 To the соптріе	Mec	29b. Signature and title of certifier	and marrier st		29c. Lice	ense number		29d. Da	ate signed (Mor	nth, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110 32 egistrar's Signature

DHMH 17 Rev 1/2001

			1 - For AMEND#25perMD State AMEND#23a+bper	State o 3-10-08,BM MD 3-10-0	f Marylan	d / Depa	artment of F	lealth a	and Me	ental Hyg	iene _{eg. No.} 2	008	
	Physicia	an	Decedent's Name (First, Middle, L     Elizabet		Midkif	f				2. Date of Deat Month March	Day <b>01</b>	Year <b>2008</b>	3. Time of Death  1:05 a _M
	/Medic Examin		4a. Facility Name (If not institution, gi			1	4b. City, Town, o	r Location of				inty of Death	1
Çası S	LAGIIIII	4	Laurel Regional	Hospital				Laure1			Prin	ce Geor	rge's
	Funeral		Social Security Number     6.	Sex 1 □ M 2 🗷 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day,	(Year)	Cou	nplace (State or Foreign untry)
Sec.	Director		579-70-6105 Usual Residence of Decedent	1   W 2	56	Yrs.			F	ebruary	22,195	2 Distr	ict of Columbia
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	ocation				<u>.</u>		10d. Inside City Limits
	Man)	tor	Maryland Prince	George's			Ве	ltsvill	le				1 □ Yes 2 🗷 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Cou	
	ath w	rall	11226 Cherry Hil	<del></del>		0 140	W- 5	20705	-1-0 (01	'(-) \/	14.1	U.S	S.A.
	items items iner n	Jun-	11. Marital Status 1 ☐ Never Married 2 ▼ Married	Armed Fo		S.   13.	Was Decedent of H If Yes, specify Cub	an, Mexican	gin? (Speci i, Puerto Ri	ican, etc.)		Black, White	
0000	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Giv Year or D	/e ates:		1 ☐ Yes 2 🔼 No	Specify:			Spe	ecify:	White
	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's I (Specify only highest g	Education rade completed)		i (Give	dent's Usual Occup	durina most	t of working	, ,	16b. Kind o	f Business/l	ndustry
V	vithin ne.	du	Elementary/Secondary (0-12)	College (1		life.	DO NOT use retire	d) _				gomery	County chools System
V	filed v Hygie ther t		17. Father's Name (First, Middle, Las		2	Tra	nsportation			First, Middle, I			
2	d be i ental   ked o	o Be	William Edward N							lizabeth		•	
2	shou ind M s mar	우	19a. Informant's Name/Relationship			19b. Mailii	ng Address (Street	and Numbe	er or Rural	Route Number	r, City or To	wn, State, Z	ip Code)
, Na	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		Wiley D. Midkiff	- Spouse			Cherry Hil	1 Road,			ille, M	lary1and	20705
ט ס	of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from		Place of Dispo emetery, cre	osition (Name of matory or other pla	ce)	Da	ite	20c. Location	on - City or T	Fown, State
Dalling	t. Pag tment tant; ijury o		4 □ Donation 5 □ Other (Spec	ify)	Ga		eaven Cemet	-		2008	Silver	Spring	, Maryland
0	Depar Impor any ir		21. Signature of Funeral Service Lic	ensee	7	] ]	2. Name and Addre <b>Hines-Rina</b> l	di Fune	eral He	ome, Inc.			aryland 20904
	Physician /Medical Examiner	1	23a. Part1. Enter the di lease, or co shock, or he it is to ni Immediate wase (Final disease or condition resulting in death)  Sequentially list conditions,	a. Hype Asys  Due to	rtensıv	ve Hear	ter the mode of dyi	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death 3/1/08
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ructive S		noa						8/20/04
,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	U	(or as a conseq		1100						0,20,01
00/0	ate be executed hysician and he burial-transit	cal		d. Morb	<del>id Obesit</del>	y							Years
O. DOX 00	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1□Live t	tcome pf pregna birth 2  Feta nant at time of d own	ıl death 3[	□Ectopic pregnanc □ Other (specify) _	у			23d.	Date of deli Month	very Day Year
Colds, r	quires tha n signed I uld be det	d by P	Part II. Other significant conditions  Hypertension, Dia	betes. <del>Spe</del>	mdvlosis	of Gerv	rical Joint	ven in Part I.					the cause of death?
Leco	The law releable has bee age 2 shot	omplete	Morbid Obesity	story of	Aothma, D	<del>epressi</del>	<del>on</del>			24a. Was a autops perfor	med?	4b. Were au prior to d death? 1 □ Yes	topsy findings available completion of cause of
g	ian: Trificat	a)	25. Was case referred to medical					26. Place	of Death	1□ Yes (Check only or	2 No	1 🗆 162	2   NO
5	ng Physici ter this ce neral direc	n: To B	examiner? 1 X Yes - 2 Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne	28a. Date		ER/Outpatie 28b. Time o	III JE DOA			e 5 Resid			cify)
JIVISIOII	or Attendir ifter death. Director: Al in by the fu	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of injury - At he	ome, farm, st	M 1 ☐	]Yes 2⊡I	-	Bf. Location (S City or Tow	treet and N n, State)	umber or Ru	ıral Route Number,
-1	24 hours a Funeral I stely filled	edical Ce		aminer: On the b			th occurred at the t nvestigation, in my						
ı.	To the To the complete	Med	29b. Signature and title of certifier	11 2	Valid	LIM	29c. Licen:	number <b>D00540</b> 9	99	2		gned (Monti	h, Day, Year)
	(		30. Name and address of person wh							g, Maryl			
	Sta		31. Date filed (Month, Day, Year)	/49 F	Registrar's Signa	ature 🚕							
	Registi	rar	MAR 0 4 20	UO CO	was St	19							

		•	State Registrar			Cer	tificate of I	Death		Re	eg. No	008	086	56
34	Physicia	an	1. Decedent's Name (First, Middle, Las							Date of Deat Month	Day	Year	3. Time of I	
	/Medic	_	Carolynn	M. Na	ıu					March	3,	2008	4:24	_ P _ M
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or		Death			ounty of Death		
	%C	où.	18722 Curry Powd  5. Social Security Number 6. S		e (In yrs. last	hirthday)	Germant If Under 1 Year		4 Hrs. 8	Date of Birth		ontgome	ry lace (State or	Foreign
	Funeral Director			□ M 2 🖾 F	66	Yrs.	Months Days		Min.	(Month, Day, eb. 4,	^{Year)} 1942	Cour	sylvan:	
	tand bw		10a. State 10b. County		10c. City, To	own or Lo	cation					1	0d. Inside City	y Limits
	Mary -f she	ţō	Maryland Montgom	erv	Ge	rman	town						1 ☐ Yes	2 ₹ No
	r 28a noti	Director	10e. Street and Number			ZIIIGII	10f. Zip Code			10	0g. Citizer	n of What Cour	ntry?	
	h witl	a D	18722 Curry Powd	er Lane			2087	74				U.S.A.		
	ems a	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of H	ispanic Origi	n? (Specify Puerto Rica	Yes or No-	14.	Race - Americ		
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ MVidowed 4 ☐ Divorced	1 □ Yes 2 □ X If Yes, Give Year or Dates:	<b>V</b> o		1 □ Yes 2 □ <b>X</b> No	Specify:		,	Sį	pecify: Whi		
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7	lled w Hygie her t	ပိ	17. Father's Name (First, Middle, Last)	2		- Ca	ie Givei	18. Mother's	s Name (Fi	rst, Middle, M				
aŭ	d be feel and a seed of	o Be	Harry Mentze					Rut	th M	evers		,		
<u></u>	shoul nd Me mark mark	ပ	19a. Informant's Name/Relationship (	Type. Print)	1	9b. Mailir	ng Address (Street				; City or T	own, State, Zip	Code) 20	874
	alth a 27 is		Cathy Ray - Daug	hter		187	22 Curry	Powder	r Lan	e, Ger	manto	own, Ma	ryland	
Je,	of Hei		20a. Method of Disposition	I Damanual from Chata	20b. Place ceme	e of Dispo	sition (Name of matory or other plac	ce)	Date		20c. Loca	tion - City or To	own, State	
Ē	Page nent d ant: If		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif				Cemetery	1	/07/20	800	Quino	cy, Pen	nsy1va:	nia
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licer	See / land		22	Name and Addre Moleswort 26401 Ric	ss of Facility	liams	P.A.,	Fune	eral Ho	me 2087:	2
a. 1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. D							aryranu	Approximate Interval Betv	)
	Physician		Immediate Cause (Final				arction						Onset and D	eath
	/Medical		disease or condition resulting in death)	_a	a consequen		arction							
	Examiner		Sequentially list conditions	b. Diab	etes									
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	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Hype	rliped									
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Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 goonths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3[	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i>	у			230	d. Date of delive Month		/ear
О.	that led by deta		Part II. Other significant conditions	contributing to death b	ut not resultin	g in the u	nderlying cause giv	en in Part I.		23e. Did tol	bacco use	contribute to t	he cause of d	eath?
g	quires n sigr	d by							_	1 □ Ye	es 2	No 3□ Prol	oably 4 📉 U	Inknown
Vital Records,	aw requir s been si s should	Completed							ŀ	24a. Was a		24b. Were auto	psy findings a	available
ř	The lav	mo								autops perform	med? 2 137 No	death? 1 ☐ Yes	mpletion of ca 2□ No	luse of
<u>e</u>		Be C	25. Was case referred to medical examiner?					26. Place o	of Death (C	heck only on				
	chysic this ce	To E	1 Yes 2 No	Hospital: 1 ☐ Inpatie			nt 3□ DOA Oth	4 🗀 Nurs				□Other (Speci	fy)	
Ē	ding Pt. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da		b. Time o Injury	Wor			. Describe ho	ow injury o	occurred		
<u>S</u>	ttend leath stor: /	icati	2 Accident investigation 3 Suicide 6 Could not b	e 280 Place of ini	iury - At home	farm st	M 1 □	Yes 2□N		Location (St	treet and I	Number or Run	al Route Num	her
Division or	I or Attend after death. Director: /	Certification:	4 ☐ Homicide determined	building, et	tc. (Specify)	, iaiii, sii	rect, ractory, office		201.	City or Town	n, State)	vamber of Trans	ar riodic ryann	001,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	(Check only 2 Medical Example 12 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example	hysician: To the best miner: On the basis o	of examination									)
	thin 2 the l	Medi	one) 29b. Signature and title of certifier	and manner st	ated.		29c. Licens	se number		2	9d. Date:	signed (Month,	Day, Year)	
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,	10		30. Name and address of person who	completed cause of o	death (Item 23	a) (Type					rial		2000	
_	10		Mikhail Gendel,	M.D. 985	0 Key	West	Avenue -	306,	Rocl	kville	, Mar	yland	20850	
300	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 5	2008 32. Registr	rar's Signature	1 6	back							
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			For State Registrar	State	of Marylan		artmer				lental Hy	giene Reg. No. 2		2 (	18657
		1	Decedent's Name (First, Middle	, Last)							2. Date of De	eath	000	3. T	ime of Death
	Physici		Anthony Rand N	igosian							Month Februa	Day 1 <b>rv</b> 28.	Year 2008	R O/	:00 A M
	/Medio		4a. Facility Name (If not institution		ımber)		4b. City	, Town, or	Location	of Death	100144		inty of Dea		.00 A
		'a-	Montgomery Gen	eral Hosp	ital			ney				Mon	tgome	ery	
	Funeral		5. Social Security Number 074–16–6707	6. Sex 1 XM 2 ☐ F	7. Age (In yrs. 91	last birthday) Yrs.	If Under	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept.	rth ay Year)	9. Bi	thplace (5 o <i>untry</i> ) W YOI	State or Foreign
	Director		Usual Residence of Decedent		91	115.					Sept.	27,1910	o Ne	W YO	rk
	land ow it		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Ins	side City Limits
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	r 28a	jrec	10e. Street and Number				10f. Zi	p Code				10g. Citizen	of What C	ountry?	
	th with	Funeral Director	4936 Walkingfe	ern Drive				208	53			Unite	d Sta	tes	
	ems ems	ner	11. Marital Status	Armed F	edent Ever in U	.S. 13.	Was Dece	edent of Hi	ispanic Or	rigin? (Spe	ecify Yes or No Rican, etc.)	0- 14.	Race - Am Black, Whi		ian,
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212	with liene. Thar	E O	Elementary/Secondary (0-12) 12	College (	(1-4or 5+)		o Eng					Print	ing		
p	other other	e O	17. Father's Name (First, Middle,	Last)		•			18. Moth	er's Name	(First, Middle	, Maiden Sur	name)		
<u>lar</u>	should be fand Mental? Samarked of umatic even	To Be	Serop Nigosian	ı					Agr	nes U	known				
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ore	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show it y or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from		Place of Disponentery, cre				Marc	h 3,	20c. Locati	-		
Ë	tment tant:		4 ☐ Donation 5 ☐ Other (S _i	pecify)	Met	tropol:				200	8	Alexa		a, VA	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		21. Signature of Funeral Service	Licensee		2	2. Name a	ind Addres	ss of Facil	^{ity} DeV	ol Fune	eral Ho	ome		
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		ш	23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final									arrest,		Interv	oximate val Between et and Death
	Physician /Medical		disease or condition resulting in death)	u.	erosclei		Cardi	.ovas	cular	Dis	ease				
1	Examiner			Due to	(or as a conseq	uence or):									
	, Low,	<u>ē</u>	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a conseq	uence of):									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
o,	an an rial-tr	Exa	resulting in death) Last	Due to	(or as a conseq	uence of):						-			
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	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29b. Signature and title of certifie		nner stated.		29	9c. Licens	e number		T	29d. Date si	gned (Mor	nth, Dav. Y	Year)
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	Examin	57	4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location of	f Death		4c.	County of Deatl	1	
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:	Funeral Director		5. Social Security Number 6. S 577–54–3134 Usual Residence of Decedent		(In yrs. la 95	St Dirtha	Months Days	Hours	Min. At	Date of Birth Month, Day 19. 23	Year)	912 New	nplace (State of untry) York	or Foreign
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and	d be f ental k ced of	Be c	William Jones						rence S			<i>-</i>		
Maryland	should nd Me mark imark	ᅀ	19a. Informant's Name/Relationship (	Type. Print)		19b. M	ailing Address (Street	and Numbe	er or Rural Ro	oute Numbe	er, City o	r Town, State, Z	ip Code)	
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altimore,	es 1 a of He fitem		20a. Method of Disposition 1 ABurial 2 □Cremation 3 □	Removal from State	20b. Pla	ace of Dis metery, a	sposition (Name of crematory or other pla	се)	Date		20c. Lo	cation - City or	Fown, State	
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	6 F 188		23a. Pan1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death.	. Do not	enter the mode of dyir	ng, such as	cardiac or re	spiratory ar	rest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition			scula	ar Accident	t					Onset and 2 week	
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	30		30. Name and address of person who											
	000		Michael J. LaPen	ta M D	445	Dofe	ngo Huzz	Annar	olie	MD 21	101			

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:26 P.M 2/29/2008 Mabel Virginia Pottier 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 12 F 87 2/27/1921 217-18-7884 Montgomery County Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Counfy 1 ☐ Yes 2 No Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6600 Riggs Rd. 20783 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sylvester Burns Annie Allnut 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert L. Pottier, Son 9004 48th Place, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 3/21/2008 Arlington, VA 22. Name and Address of Facility 4739 Baltimore Avenue lonstan Gasch's Funeral Home, P.A. Hyattsville, MD 20781 asc Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Anteroschoote Consu VASCULCE disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24a. Was an

**Physician** /Medical Examiner

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physician

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Records, P.O. Box 68760,

or Vital

Division

Hospital or Attending

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

autopsy performed

2 - No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ A/Outpatient 3 ☐ DOA

28a Date of Injury 28h. Time of (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending Investigation

6 ☐ Could not be

determined

1 Yes 2 No

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

03-01-2009

d address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

7600 Canul

TakumA) ACK.

State Registrar

31. Date filed (Month, Day, 2008 MAR 05

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 27, 2008 **Physician** Beverly Ann Popalo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Nursing Care Center Frostburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 60 214-76-5504 August 01, 1947 Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director by Funeral Baltimore, Maryland 21215-0036 Completed f Health and Mental Hygiene. Item 27 is marked other than Be 2 or other traumatic permit. Pages 1 Department of H Important: If ite any injury or ot **Physician** 

/Medical Examiner

The law requires that the death certificate be executed the burial-transit and as attending nse for ed by the should be deta has page 2 certificate Physician: director, this funeral After

Division or Vital Records, P.O. Box 68760,

To the Funcompletely t

Hospital or Attending 124 hours after death.

Re Funeral Director: Af oletely filled in by the fu within 24 the 2

01:55 PM M Birthplace (State or Foreign Country) West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 11 Yes 2 No Maryland Allegany Frostburg 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 11115 Parkersburg Road, N.W. U.S.A. 21532- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Mever Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unemployed never worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rita Lambert Vincent Popalo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21532-Maryland Trustee Frostburg Roy Troutman 176 W. Main Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State February 29, 2008 Maryland Rest Lawn Memorial Garden: LaVale 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions opntributing to death but not resulting in the underlying cause given in Part I. \$23e. Did tobacco use contribute to the cause of death? 2 with Manty Edarda 10 Yes asme Sis 2 **N**0 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg Mary and 215 MANG M. D Broadway 4 DATURNING 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

nd81

		1	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar Amend Items 23aPtII, 25 per me 8877, 03/14/08dhb  Reg. No: 0   6   6
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 12. C 9 A M  4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director		MILLENNIUM HEALTH @ FT.WASH. FORT WASHINGTON PRINCE GEORGES  5. Social Security Number 220-38-1560 1 M 2 F 66 Yrs.  7. Age (In yrs. last birthday) 66 Yrs.  7. Age (In yrs. last birthday) 66 Yrs.  8. Date of Birth (Month, Day, Year) 1 - 26-1942 9. Birthplace (State or Foreign (Month), Day, Year) 1 - 26-1942 MD.
	Maryland -f show fled at	tor	10a. State     10b. County     10c. City, Town or Location     10d. Inside City Limits       MARYLAND     CHARLES     PORT TOBACCO     1 □ Yes ※ No
	with the 3a or 28a	Funeral Director	10e. Street and Number 7535 BURCH ROAD 10f. Zip Code 20677 10g. Citizen of What Country? U.S.A.
980	tiges 1 and 2 should be filed within 72 hours after death with the Maryland 11 of Health and Mental Hygiene . If itam 27 is marked othar than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examerational Legislatical at	ρ	11. Marital Status    12. Was Decedent Ever in U.S. Armed Forces?   1
21215-0036	filed within 72 ho Hygiene. othar than "natu ant, I'v Wedicul	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER  16b. Kind of Business/Industry CALVERT CLIFFS NUCLEAR PLANT
Maryland	should be file nd Mental Hy marked oth umatic evant	To Be	17. Father's Name (First, Middle, Last)  PAUL DIGGS  18. Mother's Name (First, Middle, Maiden Surname)  CAROLYN E. PROCTOR
	1 and 2 sho Health and I am 27 Is me		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  7215 UMOJA PLACE PORT TOBACCO, MD. 20677
Baltimore,	Pages 1 and the sent of He sent of He sent of He sent of the sent		20a. Method of Disposition    20b. Place of Disposition (Name of cemetary, crematory or other place)   1   Burial   2   Xeremation   3   Removal from State (Specify)   METROPOLITAN   CREMATORY   2-6-08   ALEX., VA.
Balti	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licensee M00479  22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646
	Prysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and ed for use as the burial-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, 1 stry, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
P.O. Box 6	that the death certifice ted by the attending ph detached for use as t	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	uires that signed b lid be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown
al Records,	ician: The law requires that the certificate has been signed by th rector, page 2 should be detache	Completed	24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No
of Vital	shys this al dii	To Be	25. Was case referred to medical examiner?  1
Division	Attanding ir death. actor: After by the fune	Certification;	27. Manner of Death    Natural   5
_	To tha Hospital or within 24 hours afte To tha Funaral Dir completely filled in	Medical Co	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)
<u>.</u>	To the within To the comple	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
.0	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. L. AUFMAN 12070 OLD LINE CENTER WALDORF, MD
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 7 2008  Mar 1 7 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 810 PM James William Randall, Sr. 3000 0 lavch 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 1**½** M 2□ F 220-26-0276 78 07/03/1929 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 □ No Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 714 George Street US 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No White Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brakeman Railroad

20b. Place of Disposition (Name of cemetery, crematory or other place)

3 Ectopic pregnancy

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

5 ☐ Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of)

Due to (or as a consequence of)

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Impatient

28a. Date of Injury (Month, Day Year)

9☐Unknown

4□Pregnant at time of death

Smithsburg Crematory 03/06/2008

18. Mother's Name (First, Middle, Maiden Surname)

22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed

2

28d. Describe how injury occurred

20c. Location - City or Town, State

Smithsburg, MD

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Approximate Interval Between Onset and Death

Minnie Mae Knight

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 George Street, Hagerstown, MD 21740

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

determined

27. Manner of Death

2 Accident

3 ☐ Suicide

1 Natural

2 No

disease or condition resulting in death)

Roger Carl Randall, Sr.

1 ☐ Burial 2 【ACremation 3 ☐ Removal from State

Son

19a. Informant's Name/Relationship (Type. Print) James W. Randall, Jr. /

4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License

Director

Funeral

ģ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner

and as the burial-tran

Physician/Medical

by

Completed

Be

2

The law requires that the death certificate be executed attending physician for use as the burial the signed by has certificate To the Hospital or Attending Physician: After this Director: in by the

Division or Vital Records, P.O. Box 68760, Certification: Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number -1284-OHCHICAVE HAGERSTON who completed cause of death (Item 23a) (Type, Print) UAHREA 5H4+ un 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 6 2008 Registrar DHMH 17 Rev 1/2001

7. Age (In yrs. last birthday)

Physician
/Medical
Examiner

Carl Richard Robbins

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

**Funeral** 

10 M 2□ F Months Days 004-16-0409 84 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 7101 Bay Front Drive, #3309 21403 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Maries 2 No ff Yes, Give Year or Dates: 1944–46 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemist 5+ 17. Father's Name (First, Middle, Last) Be Wendell I. Robbins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
644 Pinewood Drive Annapolis, Maryland 21401 Karen Meyer/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/5/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 21. Signature of Tuneral Service Licentee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (one s a consequence of): **Physician** /Medical **Examiner** Sensis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Examine sician and burial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for a in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Cardionyopa Completed 24a. Was an 1∐ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Mnpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 161829

4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Min. March 10, 1923 Maine 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry National Institute of Standards 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth D. Rogerson

28, 2008

Month

February

3. Time of Death

4:21

 $P^{M}$ 

Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year

> 23e. Did tobacco use contribute to the cause of death? 4.7 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

20c. Location - City or Town, State

Baltimore, Maryland

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed

2/2

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Annepolis,

Reynaldo (31. Date filed (Month, Day, Year) MAR 0 3 2008 17CC- II, M.D.
32. Pigistrar's Signature

State

Registrar

08-01906 Dajaun Robinson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician		egistrar . Decedent's Name (First, Midd	ile,Last)							Date of Dea Month	Day	Year	L	e of Death
Medical Examine	er	Dajaun Demetr	ic Rob	inson						March 7,	2008			40 hrs
4	4	a. Facility Name (if not instituti		and number)		4	b. City, Town, or Westminste		Death			County of E rroll	Jeath	
		Carroll Hospital Cent		12.4	- (la con la et la	vieth dow)	If Under 1 Yea		24Hrs	8 Date of Bi			9. Birthplace	(State or
Funeral	5	. Social Security Number	6. Sex		e (In yrs. last b		Months Days		Min.			F	oreign Country)	MD
Director		220-79-2344	1 X M 2	F		Yrs.	4			Nov C	00 200	57		1-112
any	_	Jsual Residence of Decedent 10a. State 10b. County			10c. City, Tov	vn or Location	on							nside City Limits
<b>*</b>	1		arroll		1	Westm	inster						1 [	Yes 2 X No
Maryland 28a-f show datonce.	ᆰ	10e. Street and Number					10f. Zip Code			T	10g. Citize	n of What	Country?	
death with the Maryland or items 23a or 28a-f sho must be notified at onc.	Director	1500 Conros	e Driv	e			21	157				USA	7	
with t		11. Marital Status			Ever in U.S.	13. Wa	s Decedent of His es, specify Cubar	spanic Origin	n? (Spe	cify Yes or N	lo- 1	4. Race - A	American Ind	dian, Black,
death r iten	Funeral	1 Never Martied 2 NA	1		No				i deito i	iloan, etc.)			Blac	k
V 5 5	ᆰ	3 Widowed 4 D	ivorced If Yes, C	9S:	N/A		Yes 2 X No		in al of use	ark dono		pecify:	ness/industr	
hours		15. Decedent's Education (Sp		est grade con ollege (1-4 or		during mo	t's Usual Occupa ost of working life	. DO NOT	ise retire	ed)	100.14	id or Edon	1000/11/10001	,
36 in 72 han "Han "	Completed	Elementary/Secondary (0-12	'	illege (14 oi	3.,		N/A				ļ	N	I/A	
5-003 ed withi tygiene. other th	탉	N/A 17. Father's Name (First, Middl	e, Last)				- IV/A	18.Mother's	Name (	First, Middle	, Maiden S			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		Domonique D	Robin	son				Feli	cia	E. Cos	stley			
D 21215-C should be filed v and Mental Hygin 7 is marked oth natic event, the	ᆰ	Domonique D.  19a. Informant's Name/Relation	nship (Type, Pr	int )			Address (Stre							
MD and 2 sho alth and m 27 is	-	Joyce Costley	//Grand	<u>mother</u>	Look Black	1500	Conrose	Drive	e W	<u>estmir</u> _{Date}	ster	ocation - C	2115 City or Town,	7 State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f she of the remains the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 X Burial 2 Cremati	on 3 Rer	moval from S	tate crer	matory or otl	her place)							
Page Page nent c	Ш	4 Donation 5 Other	Specify:		Meado	ow Bra	anch Cem	etery	3/1	4/2008	3   We	<u>stmir</u>	ster,	MD
Baltimore, ML permit Pages land 2 s Department of Health a Important: If item 27 injury or other traum	1	ignat of Funeral rvio	e Lice ee	_		22.	PP1 PC Sddr F	inera	l Ho	me and	l Chaj	ρe⊥,	P.A.	21157
	4	2. Pirt I. Enter the diseas.	or complication	ns that cause	d the death. Do	o not enter t	412 Wash	ingto	n KO ardiac or	respiratory a	errest, sho	ck, or hear	rt Ap	proximate interval
Physician Medical		ilure. List only one caus	se on each line	ł.			In Infancy						Be	tween Onset and Death
aminer	1	Immediate Cause (Final diseas or condition resulting in death)			sequence of):	Deaur_	ш шшаку	(DODI)						
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•	iner	if any, leading to immediate cause. Enter Underlying Cause	se	(or as a con	sequence of):								İ	
	Examine	(Disease or injury that initiated events resulting in death) Las	D	(or as a con	sequence of):									
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Box 68760, death certificate be executed the attending physician and dror use as the burial - trans	Medical	X UNPENDED					f per ME g	8/8 4/	10/08	amn	236	i. Date of o	delivery	
3760 ficate b g physi		IF FEMALÉ: 23b. Was decedent pregnant ir		Live birth	ome of pregnar	-	etal death 3	Ectopic	c pregna	ncy		Month	Day	Year
x 68 h certi lendin use a	icial	past 12 months?	4	=	at time of death	- =	ther (Specify)							
_ 0 = 0	Physician/	1 Yes 2 No 9 L		Unknown			- 4 - 4 - 4 - 4	sives in Do	set I	23a Di	d tobacco	use contri	bute to the c	ause of death?
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Atter Atter or deat rector by th	icat						eet, factory, office	e building, e	tc.	28f. Locatio	n (Street a	and Number	er or Rural F	Route Number, City
Div tal or rs after	Certification:			(Specify) Fo	und at h	ome				1500 C	n, State) On-rose	e Dr.,	Westmi	nster,MD
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detaxed.		29a. Certifier 1 Certifying	- Dhysisiany T	a the best of	my knowledge	death occ	urred at the time,	date and pl	ace, and	due to the o	ause(s) ar	nd manner	as stated.	use(s)
To the Hos within 24 h To the Fur completely	Medical		and r	manner state	ed.	J/or investig		nse number					ed (Month,	
	Σ	29b. Signature and title of cer	titier	$\supset \alpha$	$\sim$			C.M.E.			- 1	rch 8, 2		,,,
MIL		Patrille		OK	رعا	12-1			-					
		30. Name and address of per Patricia Aronica-Po			of death (Item 2 : Medical E		111 Penn	Street, B	altimo	re, MD 21	201			
St	ate	31. Date filed (Month, Day, Ye			trar's Signatur									
Regist		MAR 1	3 2008	Blok	we to	1	afe							
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OCME

		•	For State Registrar	State of Mary		artment of H			giene Reg. No.2 0 0 8	08665
			Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physici /Medic		Charles A	lbert Rho	odes, Ji	<b>:</b>		March	Day Year 1 2008	4:00a M
	Examin		4a. Facility Name (If not institution, give st		•	4b. City, Town, or	Location of Death	1 1011 111	4c. County of Dea	
			Golden Living Cent	ter		Westmins	ster		Carrol:	L
	Funeral		Social Security Number     6. Sex	7. Age (In	yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year) 9. Bi	thplace (State or Foreign ountry)
	Director		213-58-1592	M 2LIF	59 Yrs.			8/20/1		
	and *	1	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	danyi feho	ö	MD. Carr	roll V	Vestmins	ter				1 ☐ Yes 2 🛣 No
	288-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	3a or	ā	1234 Washington Roa	ad		2115	7		USA	
	ter death with the Marylan Iteme 23a or 28a-f show Der munt be politied at	Funeral		2. Was Decedent Ever	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	- 14. Race - Am	
٥	or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				o Rican, etc.)		
200	rai',	1 by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	white
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural; or teme 23a or 28a-f ehow int, the Madical Eram ref must be multified a	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	during most of wor	rking	16b. Kind of Business	s/Industry
2	within	m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired			MaCosmi als	Construction
7	e filed v I Hygie other I		17. Father's Name (First, Middle, Last)		COn	struction		ne (First, Middle	Maiden Sumame)	Constituection
Ĕ	a la b	o Be	Charles Albert Rho	des Sr				Elizabe		
Σ	2 should be and Menta is marked aumatic ev	ř	19a. Informant's Name/Relationship (Typ	•	19b. Mail	ing Address (Street			er, City or Town, State,	Zip Code)
S	l end 2 s lealth ar im 27 ls her trau		Charles A. Rhodes,		on 122 (	Carnival I	Orive. Ta	anevtown	, Md. 2178	7
ē,	~ <u> </u>		20a. Method of Disposition	2	Ob. Place of Disp			Date	20c. Location - City of	
Ê			1 ☐ Burial 2 ☆ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		Crematio	. ე	/ 4 /08	Hampstead	FM
altimore,	permit. Page Department of Importent: If eny injury of once.		21. Signature of Funeral Service License	0 1	m 00741 2	2. Name and Addres	ss of Facility			
ñ	9 0 E 8		I Standa L	Lemme	er	Eline Fund	eral Home	e, 934 S	outh Main	Street
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the	death. Do not en	iter the mode of dyin	g, such as cardiad	or respiratory a	rrest,	Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition			Leuker	113-			Onset and Death
	/Medical		resulting in death)	Due to (or as a co	nsequence of):		(10			1
Н	Examiner		Sequentially list conditions b.							
	ъ <u>н</u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as a so	neequanea of):					
	and and trans	Examin	that initiated events c. resulting in death) Last	Due to (or as a co	neadhanca ot).					
8760,	The law requires thet the death certificate be executed the hes been signed by the attending physicien and hage 2 should be deteched for use as the burial-transit			000 to (01 as a co	misaquanca or).					
687	phys the	dical	d.							
×	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome of p	regnancy				23d. Date of d	elivery
Box	atter affor u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
o.	the d	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
ري م	res thet the designed by the a	by P	Part II. Other significant conditions conf	inbuting to death but no	ot resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Ď	w require been sig should b							10	Yes 2⊠No 3⊡1	Probably 4 Unknown
Records,	aw re	piet						24a. Was		autopsy findings available
ř	The lav	Completed						auto perfo	ormed2 death	
g	ician: Th certificete rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only		
<u> </u>	Physician: this certific al director,	To	1 Tyes 2 No	ospital:	2 ER/Outpatie	ont 3 DOA Oth	er: Nursing H	dome 5 ☐ Resi	dence 6 Other (Sp	necify)
Division of Vital	Attending Physician: r death. ector: After this certifici by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time Injury	of 28c. Injur Wor	y at k?	28d. Describe	how injury occurred	
<u>sio</u>	uttsndi death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No			
$\leq$	를 를 들	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S		treet, factory, office			Street and Number or I wn, State)	Rural Route Number,
	pitai erel milled		20a Cartifier 15 Cartifying Dhya	iniana Taraha basa at m	leandead.ac	M				
	To the Hospital or At within 24 hours efter of To the Funerel Direct completely filled in by	edicai	29a. Certifier (Check only one)  1. Certifying Phys 2 Medical Examin	er: On the basis of exa and manner stated	amination and/or i	un occurred at the tir nvestigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	orthin orthin	Me	29b. Signature and title of certifier	11 11		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
	WJZ		> Deluc	// gelm	•	1000	59943		March =	5, 200P
	3		30. Name and ad ress per on cor	mpleted cause of death	ı (Item 23a) (Type	, Print)			, .	t
	4		princ Asselves	295 SP	ner Are.	SviR 3	107 NR	stminste	1 MO	21157.
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature			,		
1	Regist	rar	MAR 0 4 2	008 Marie	with .	Onestel				

DK

State Registrar 31. Date filed (Month, Day, Year)

OSEI-BOAMAH, EMMANUEL, M.D., 500 MEMORIAL AVENUE, CUMBERLAND, MD 21502

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

,		1 - For State Registrar	otato ot mai,	Ce	rtificate of	Death	Re	eg. No.	008	08667
Dhysisi	00	1. Decedent's Name (First, Middle, L	ast)				2. Date of Deat Month	Day	Year	3. Time of Death
Physici /Medic		Anna	M. Rood				February		2008	7:47 p ^M
Examir	er	4a. Facility Name (If not institution, gi	ve street and number)			r Location of Death		4c. Co	unty of Death	
ering of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section	14	Holy Cross  5. Social Security Number 6.		n vrs. last birthday		Iver Spring If Under 24 Hrs.	8. Date of Birth		Montgo	omery ace (State or Foreign
Funeral			1 M 2 <b>X</b> F	86 Yrs.	Months Days	Hours Min.	(Month, Day,		Count	ry)
natural", or Items 23a or 28a-f show addical Examiner must be notified at		579-44-0891 Usual Residence of Decedent		00			July 20,	1921	Distric	ct of Columbi
ow		10a. State 10b. County	10	c. City, Town or L	ocation				10	d. Inside City Limits
-f show lied at	to	Maryland Prince	e George's		Hyatts	ville				1 ☐ Yes 2 🗷 No
Item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Medical Ex-miner must be notified at	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen	of What Count	ry?
3a o		6700 Belcrest R	nad #521			20782			U.S.A.	
ms 2	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No-		Race - America	
or Ite		1 ☐ Never Married 2 ☐ Married	1 Yes 2 No		1 ☐ Yes 2 🗷 No		ricari, etc.		Black, White, e	
E A	b	3 X Widowed 4 ☐ Divorced	Year or Dates:		TE Tes ZLATIVO	Specify.		Sp	ecify:	White
lical	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Dece	edent's Usual Occup e kind of work done	ation during most of work	ina	16b. Kind	of Business/Ind	ustry
Mec	혈	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)		_		
the the	5	12		C:	atholic News				holic Chu	irch, USA
ven	Be	17. Father's Name (First, Middle, Las	st)		;	18. Mother's Name	e (First, Middle, N	Maiden Su	rname)	
atice	၉	Orazio Vagnoni				Maria	C. Capone			
an me		19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street	and Number or Rui	ral Route Number	, City or To	own, State, Zip	Code)
tem 27 l other tra		Catherine A. Gal	lerizzo - Siste	r 609	Marshall Mar	nor Drive,	Silver Spr	ing, M	aryland 2	20905
r othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3		20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac		Date	20c. Locat	ion - City or To	wn, State
Important: If any injury or once,		4 □ Donation 5 □ Other (Spec		Fort Line	oln Cemeter	y 03/0	7/2008	Brent	wood, Ma	ryland
Important: any injury once.		21. Signature of Funeral Service Lic	ensee		22. Name and Addre		Homo Inc			22,17430 25411
E & 6	2	Aleson M G	corax		11800 New Ha	ampshire Ave	enue, Silv	er Spr	ing, Mary	yland 20904
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the	e death. Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
sician	10	Immediate Cause (Final								Onset and Death
dical		disease or condition resulting in death)	a. Sepsis  Due to (or as a co	onsequence of):						Days
iner		4		ract Infec	tion				1	Days
961 ZT	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury	Due to (or as a co		CIOII					Lays
ansit	Ę.	Cause (Disease or injury that initiated events								
ial-tra	Examiner	resulting in death) Last	Due to (or as a co	onsequence of):						
e pri			d							_
ng physician and as the burial-transit	Medical									
attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf		Π <u>Ε-</u>			23d	. Date of delive	ry
d for	icia	in the past 12 months? 1 ☐ Yes 2 🖾 No	1□Live birth 2□ 4□Pregnant at tim		☐ Ectopic pregnanc: ☐ Other (specify) _	у	<del></del>		Month	Day Year
tached	Physician/	9 Unknown	9□Unknown							
be deta		Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did tot	oacco use	contribute to th	e cause of death?
od bi	d by						1 □ Y	es 2 🗆 l	No 3 Prob	ably 4 🗷 Unknown
should t	Completed						24a. Was a	n a	24b. Were autor	osy findings available
2 23	d m						autops	sy	prior to con death?	npletion of cause of
ils certificate ha		OF Man and referred to medical						2 X No	1 ☐ Yes	2 No
recto	Be	25. Was case referred to medical examiner?	Hospital:		ant 3D DOA Oth	26. Place of Deather:				
al di	은	1 ☐ Yes 2 🕱 No 27. Manner of Death	1 Impatient 28a. Date of Injury	2 ER/Outpatie	SUL DON	4 Li Nursing H	ome 5 Reside			()
funeral	Certification:	1 X Natural 5 ☐ Pending	(Month, Day Y		Wor	rk?  Yes 2 □ No	zou. Describe no	ow injury o	ccurred	
by the f	cati	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	ho	At home form		res 2 INO	006 1		t t	(Deuts Musshan
in by	Ħ	4 ☐ Homicide determine	d 28e. Place of injury building, etc. (		ireet, factory, office		28f. Location (St City or Town		rumber or mura	I Houte Number,
completely filled in by the										
ely fi	ca	(Check only 2 Medical Ex	Physician: To the best of n aminer: On the basis of ex	amination and/or						
completely filled in	Medical	one)	and manner stated	1.	One Linear	e number		0d Det-	ianod /84	Day Vossi
og -	2	29b. Signature and title of certifier	1-11		29c. Licens	e number	2		igned (Month,	
V		700001	TO MR		D	32332		Fet	ruary 29	, 2008
1		30 Name and address of person wh								
		Suresh K. Gupta,			, #220, Sil	ver Spring,	Maryland	20902		
Sta		31. Date filed (Month, Day, Year)	32 egistrar's	Signature	and a					
Regist	rar	MAR 0 4 2	2008 Secur	15 19						
147 Day 4/0	004									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 🗷 F Months Days Hours 97 June 12, 1910 Director 218-38-7342 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Russell Avenue, #409B 20877 U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Completed by Specify Caucasian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk 12 Education is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William A. Wallace Lulu Finley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a James Restorff - Son 5902 Chestnut Hill Road, College Park, Maryland 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 03/06/2008 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEACH disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 Other (specify) ed by the a detached f 9☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 3 Probably 4 Unknown 1 | Yes 2 | 1 | 10 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has r autopsy performed 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 📴 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

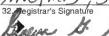
Registrar

MAR 0 4 2008

30. Name and address of person who completed cause

29b. Signature and title of certifier

MARLENET. 31. Date filed (Month, Day, Year)



of death (Item 23a) (Type, Print)

N. FREDERICK AUE,

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01920 State of Maryland / Department of Health and Mental Hygiene Ronald Richardson Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 8, 2008 0643 hrs Medical Examiner Richardson Ronald 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale Franklin Square Hospital If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign NOTTh 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Davs Hours Country Carolina Director 19. 1 X M 56 106-44-5675 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No s 23a or 28a-f show e notified at once. Baltimore Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 21220-3454 12 Cedar Drive Apt.D Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc. Baltimore, MD 21215-0036
pernit. Pages 1 and 2 should be filed within 72 hours after death wi
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items
injury or other traumatic event, the Medical Examiner must be: Armed Forces? Never Married 2 Married 1 X Yes Black Specify: 1 Yes 2 X No specify: If Yes, Give Year or Dates: Divorced 3 Widowed <u>\$</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) None Unemployed 12 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Richardson Norman Giddings Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 12462 Old Colony Drive Upper Marlboro, MD 20772 Rakeen Richardson - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Marvland Vet's Cemt. Mar. 19. 2008 Cheltenham 22. Name and Address of Facility ewar lunera ome, n Donation 5 Other Specify: 21. Signature of Funeral envir Lin nsee 4001 Benning Road, NE Washington, DC 20019 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart een Onset and **Physician** failure. List only one cause on each line Death /Medical Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit sician/Medical AMENDED 23a,27 per ME g878 4/4/08 amh X UNPENDED the attending physician led for use as the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy Year Month Day Ectopic pregnancy 3b. Was decedent pregnant in the Fetal death Live birth 2 | past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown ģ Completed Be Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate has funeral director, page 2 s 24 hours after death. Director: pletely within 2 To the 1

				24a. Was an autopsy performed?	prior to comple death?	etion of cause of
25. Was case referred to medical			26.Place of Death (Check	only one)		
	spital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nursi	ng Home 5 Residenc		
27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury		
2 Accident Investigation 3 Suicide 6 Could not be determined	e 28e. Place of Injury - At (Specify)			28f. Location (Street and or Town, State)		oute Number, City
29a. Certifier (Check only one) 2 Medical Examiner:	n: To the best of my knowle On the basis of examination	edge, death occurred at and/or investigation, in	the time, date and place, ar my opinion, death occurred	d due to the cause(s) and at the time, date and place	manner as stated. e, and due to the cau	se(s)

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

OCME

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 8, 2008

State Registrar

Medical

Tasha Greenberg MD. 31. Date filed (Month, Day,

29b. Signature and title of certifier

		For State Registrar	Otato or iviaryio	•	artment of He tificate of D		-	Reg. No.	08 08670
Physicia /Medic	ın	Decedent's Name (First, Middle, Last     RUDOLPH SMITH J					2. Date of De Month FEBRUAR	Day	3. Time of Death 3:43 A. M
Examine uneral		4a. Facility Name (If not institution, given SOUTHERN MARYLAND 5. Social Security Number 6. S	HOSPITAL Flex 7. Age (In ye	rs. last birthday)	4b. City, Town, or L  CLINTON  If Under 1 Year  Months Days	ocation of Death  If Under 24 Hrs.  Hours Min.	8. Date of Birt	h	of Death  E GEORGE 'S  9. Birthplace (State or Foreign Country)
ector		577-74-8055 1 Usual Residence of Decedent	₩ 2□F	56 Yrs.	World Days	TIOUIS WITT.			WASHINGTON, DC
dical Examiner must be notified at	or	10a. State 10b. County		City, Town or Lo ASHINGTO					10d. Inside City Limits 11√21 Yes 2 □ No
	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
		1321 C ST., N.E.	12. Was Decedent Ever in	118 12 1	20019	panie Origin? (St	pacify Vas or No		STATES e - American Indian,
	by Funeral	11. Marital Status  1   Never Married 2 Married 3   Widowed 4 Divorced	Armed Forces?  1  Yes 2 N No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 □ Yes 2 No	Specify:	o Rican, etc.)	Blac	ck, White, etc.
	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	i (Give	dent's Usual Occupat kind of work done du DO NOT use retired) GROUN	tion uring most of wor DS KEEPI		16b. Kind of Bu	usiness/Industry ATE
	BeC	17. Father's Name (First, Middle, Last,	)		-	18. Mother's Nam		Maiden Surnan	ne)
	卢 .	RUDOLPH SMITH S  19a. Informant's Name/Relationship (	Type Print)	19b Mailir	ng Address (Street ar	MARY F		er City or Town	State Zin Code)
		SONORA SMITH/SIS	**	I	BOX 62812			-	•
		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State		natory or other place	1	Date		City or Town, State
once,		4 □ Donation 5 □ Other (Specification of Signature of Funeral Service Lice)		10 22	EMORIAL P.  Name and Address PTTOL MOR	of Facility		LANDOVI	ER, MD. D.C. 2000 E., N.E. WASH.,
al er	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons  C	equence of):					
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pred 1 ☐Live birth 2 ☐ Fd 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)				te of delivery onth Day Year
	þ	Part II. Other significant conditions of	contributing to death but not r	resulting in the u	nderlying cause giver	n in Part I.	23e. Did t		tribute to the cause of death?  3 ☐ Probably 4 ☐ Unknown
Ì	Completed						24a. Was auto perfo 1 Yes	psy prmed?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	Othor	26. Place of Dea		<i>one)</i> dence 6 □Oth	ner (Chasita)
	$\vdash$	27. Man r of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,	28b. Time o	f 28c. Injury Work			how injury occur	
	Certification:	3 Suicide 6 Could not be determined			eet, factory, office		28f. Location ( City or To		ber or Rural Route Number,
	edical		nysician: To the best of my k miner: On the basis of exam and manner stated.						
	Me	29b. Signature and Atlefor certifier	4.4		29c. License			-	ed (Month, Day, Year)
	- 1		Paal /						
completely filled in by the		30. Name and address of person who	completed cause of death (II	tem 23a) (Type,	Print)	38120		Feb 27	1008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 4.00 **Physician** ebruary , 2008 Mildred L. Shaak /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner enter Olen Baltimore Mashington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗶 F 257-22-3689 84 1924 Georgia Director Jan. 20, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County f show ages 1 and 2 should be filed within 72 hours after death with the Maryla not Health and Mental Hyglenc. It file T27 is marked other than "natural", or items 23a or 28a-f show or or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Anne Arundel Severna Park MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1202 Purnell Road 21146 USA by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give V Yeer or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Home** Homemaker permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 Is marked other than any injury or other traumatic event, the Once. 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk unk ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1202 Purnell Road Severna Park, MD 21146 Jo Ellen Touchette/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar. 04, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, VA Mt. Comfort Cemetery 4 ☐ Donation 5 ☐ Other (Specify) P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee P.A. Severna Park Funeral Home 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Immediate Cause (Final HEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): OSCIPLLATIVE PULMONARY DICEAGE Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 27. Mary er of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, A

Name and eddress of person who completed gause of death (Item 23a) (Type, Print) Hos

> 2008 3

Year)

pital our re

strar's Signature

29c. License number

29d Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Day Year **Physician** CHARLOTTE MAXINE 25 SULLIVAN M 80 1340 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 👿 F 86 220-40-1173 Director 12/19/1921 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Bedford Bedford 1 ☐ Yes 2 👿 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 610 Teaberry Road 15522 USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. Completed by 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Glass Cutter Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Combs Gladys Gay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Linda L. McCoy / Daughter 610 Teaberry Road, Bedford, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Cumberland Crematory 02/26/2008 Cumberland, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 10 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 420:0W disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the bunal-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 🗌 No 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours af To the Funeral D completely filled is To the Hospital 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

2 Thes

State

Registrar

Kobert Welik M.D. 31. Date filed (Month, Day, Year) FEB 2 6 2008

29b. Signature and title of certified

(Check only

one)

904 Seton 32. Registrar's Signature

DOCTOR

nd manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

マスもつら

29d. Date signed (Month, Day, Year)

Drive, Cumberland, MD 21502

	Phy: /Mc Exa	sic edi mi
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 03 08 RONALD NEIL STERNE 03 0110 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 78 212-24-0541 08/11/1929 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No LaVale permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany Injury or other traumatic event, the Medical Examiner must be notified once. Allegany MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 933 Tara Way Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 þ White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Superintendent 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Orland Sterne Daisy Adaline Ayersman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Norma L. Sterne / Wife 933 Tara Way, LaVale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/07/2008 Cumberland, MD Sunset Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service License 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition emorrhage ian MINUTES resulting in death) cal Due to (or as a consequence of ıer HILLEUR AIN MINUTES Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last in to or as a consequence of: Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2. ☑ No 1∏ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Pers

nos

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 4

32. Registrar's Signature

Cumberland, MO 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #22, nls, per fh, 02/22/08, Allegany Co. State of Maryland / Department of Health and Mental Hygiene? | | | 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** WILLIAM SPAID 02 2008 1925 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG • 17,1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1**X** M 2□ F 78 WEST VIRGINIA Director 233-60-3369 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2√2 No Director WV HAMPSHIRE YELLOW SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or HC 87, BOX 26 26865 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examiner 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Completed by Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **FARMER** FARMING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM F. SPAID GOLDIE ANDERSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRED H. SPAID / NEPHEW HC 87, BOX 46, YELLOW SPRING, WV 26865 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) SHILOH CEMETERY 02/15/2008 LEHEW, WV 21. Signature of Funeral Service Licensi e 22. Name and Address of Facility UPCHURCH FUNERALHOME, P.A. 202 GREENE STREET, CUMBERLAND, 21502 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Immediate Cause (Final Physician pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 🗷 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [2] Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Natural s after death.

I Director: A
id in by the fu 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral ( the Hospital Medical ( t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0023371 2

DHMH 17 Rev 1/2001

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State Registrar

ORIGINAL

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Seton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 2 2 2008 man

32. Registrar's Signature

			Pleas	e Type or Pri	nt in Bl	ack In	delible In	k. Ensure A	All Copies	s Are	Legible.		
			_ For	State of M	aryland	/ Depa	artment of	Health and	Mental Hy	/giene		~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	-
			1 - State Registrar			Cei	rtificate c	f Death		Reg. No.	2008	U55/	C
			1. Decedent's Name (First, Middle,	Last)					2. Date of D	eath	Voor	3. Time of Death	
Én	Physici /Medi		Lillian	Iz	ora		Shafer	3	Month Februa	ry 22	2, 2008	4:30 P	N
	Examir		4a. Facility Name (If not institution,					n, or Location of Deat	h	4c.	County of Death		
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ь	Funeral		,	. Sex 7. Ag 1  M 2	ge (In yrs. la: 98	st birthday) Yrs.	Months Da	ar If Under 24 Hrs. /s Hours Min.	(Month, D	irth ay, Year)	9. Birth	place (State or Forei	Эn
	Director		234–40–3359 Usual Residence of Decedent	A		113.			03/17/	1909	Mar	yland	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation			-		10d. Inside City Limit	s
	Mary -f sh	to	MD All	egany		Fl	intston	е				1 ☐ Yes 2 💢 N	0
	r 28a	irec	10e. Street and Number				10f. Zip Cod	9		10g. Citi	izen of What Cou	intry?	
	h with	Funeral Director	21275 Nat	ional Pike,	NE			21530			USA		
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent	of Hispanic Origin? (S Suban, Mexican, Puer	Specify Yes or N	0-	14. Race - Amer Black, White		
9	after or ite mlne	F	1 ☐ Never Married 2 ☐ Marrie				1 ☐ Yes 2 ∏ I		to Filoari, Cto.				
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2	Hygie Hygie ther int, th	ပိ	17. Father's Name (First, Middle, La	ast)			Tromeme	18. Mother's Nar	me (First, Middle	e. Maiden			
aŭ	d be ental ced o	Be C	John	William		Morg	gan	Martha	Plo	easar	nt Ba	rnes	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	٩	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Str	eet and Number or R	ural Route Num	ber, City o	or Town, State, Z	ip Code)	
S	Ith ar		Grace S. Hebner	/ Daughte:	r		-	al Pike,				. ,	
<u>ئ</u>	f Hea f Hea tem		20a. Method of Disposition		20b. Pla	ce of Dispo	osition (Name of	n/aca)	Date	20c. Lo	ocation - City or 1	own, State	
JO T	Page ent o nt: If	1	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				,	Park   02/2	26/2008	Cui	mberland	l. MD	
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ä	permi Depar Impor any Ir once,		Moure K	Uday		4	04 Deca	tur Street	, Cumbe	rlan	d, MD 2	1502	
ř.			23a. Part . Enter the disease, or c shock, or heart failure. List o	omplication that cause	d the death.	Do not ent	ter the mode of	dying, such as cardia	c or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	lly one company of	ine.	8.						Onset and Death	
	/Medical	Ш	resulting in death)	a. Dir to (or as	a conseque	ence of):	~					gens	_
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	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events	Due to (or as	a conseque	ence of):							
	ecute ind trans	Examiner	that initiated events resulting in death) Last	с									
60,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):							
6876	ate b hysic the b	lica	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	d									
9 x	w requires that the death certificate to been signed by the attending physication be detached for use as the total death and the state of the total death.	Physician/Medical	IF FEMALE:	00-11									
Box	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal o	death 3	⊒Ectopic pregna				23d. Date of deli Month	very Day Year	
	ne de the a	/sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time of dea	ath 5L	Other (specify	)				,	
P.0	that the		Part II. Other significant condition	s contributing to death b	out not result	ing in the u	nderlying cause	given in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?	
ds,	signe d be	Completed by	I anter	•>~		Ü	, ,		1	Yes 2	□ No 3 □ Pro	bably 4 KUnknow	٧n
Ö	v requ	etec	(47)						040 1000		Toth Wasses	ann findings and b	la.
Rec	has has	Ig II							24a. Wa	opsy formed?	prior to c	topsy findings availat ompletion of cause o	f
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or	Phy or this eral d	 7	27. Manner of Death	28a. Date of Inju	ury 2	28b. Time o		njury at Vork?	28d. Describe		6 XOther (Spec ry occurred	Living	
on	nding th. : Afte e fune	ţi	1 Natural 5 □ Pending 2 □ Accident investiga	(Month, Da tion	ay Year)	Injury		Vork? □ Yes 2 □ No					
/isi	Atter r deal ector by the	Certification:	3 ☐ Suicide 6 ☐ Could no	ad Zoe. Place of In	jury - At hom	ne, farm, str	reet, factory, offi	ce	28f. Location	(Street an	nd Number or Ru	ral Route Number,	
Ö	al or after Direction	erti	4 ☐ Homicide determin	building, e	tc." (Specify)				City or To	own, State	e)		
	pspit hours unera y fille			Physician: To the best									
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page	edical	(Check only 2 Medical E	kaminer: On the basis of and manner st		on and/or in	ivestigation, in r	ly opinion, death occ	urrea at the time	e, date and	a place, and due	to the cause(s)	
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	nes		Beverly C				morial	Avenue, Cu	umberlan	nd, M	D 21502	<u></u>	
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	Examin	7	4a. Facility Name (If r	not institution, gi	ive street and nun	nber)		4b. City,	Town, or	Location o	of Death		4c.	County of Dea	th	
			Wilson He	alth Ca	re Cente	r		Ga	aith	ersbu	rg		Mo	ontgome	ry	
	Funeral Director		5. Social Security Nur 254-26-73		Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under Months	1 Year Days	ff Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Jan. 1	y, Year)		thplace (State o	r Foreign
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	or 28a-	Funeral Director	10e. Street and Numb	oer				10f. Zip	Code				10g. Cit	izen of What C	ountry?	
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			23a. Part1. Enter the shock, or heart		mplications that can be one cause or early	aused the deat ach line.	h. Do not ent	er the mode	e of dyin	g, such as	cardiac o	or respiratory ai	rest,	-	Approximate Interval Bets Onset and	ween
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	Vithin To th comp	Me	29b. Signature and tit	tle of certifier				29c	License	e number			29d. Da	te signed (Mon	th, Day, Year)	
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	/Medic Examin		Mary S  4a. Facility Name (If not institution)	tein , give street and nui	mber)		4b. City, Town,	or Location of De	March	1 4c. Ce	2008 ounty of Deat	
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	Director		220-60-4852	1□M 2∏F	92	Yrs.	Ivionins Days	Hours M	Sept.			nada
	and w		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or L	ocation					10d. Inside City Limits
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	the 728a-	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	untry?
	h with	a D	9530 Briar Gle	n Way				20886	5	Uni	ted St	ates
õ	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It and Mental Hyglene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 ☐ Never Married 2☐ Marri	If Yes, Gir	orces? 2 No ve X	n U.S. 13.	Was Decedent of If Yes, specify Cub		(Specify Yes or Nuerto Rican, etc.)	0- 14	I. Race - Ame Black, White	ncan Indian,
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Maryland	ind 2 shou alth and M 27 is mai er traumat		19a. Informant's Name/Relationsh Peter B. Stein			1	ing Address <i>(Stree</i> <b>) Briar</b> G			-		Zip Code) , MD 20886
aitimore,	Pages 1 and 2 lent of Health a nt: If item 27 is ry or other trau		20a. Method of Disposition  1 ☐ Burial 2 【Cremation  4 ☐ Donation 5 ☐ Other (Sp.		Ctata	b. Place of Disp cemetery, cre etropol crem	osition (Name of ematory or other pla	Ma	rch 3		ation - City or	Town, State
Balti	permit. Pages. Department of I Important: If ite any Injury or of		21. Signature of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service of Funeral Service				22. Name and Addr Park Dri	ess of Facility I	eVol Fur	eral 1	Home.	10 East Deer
Н	- 111		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that o	caused the d			ing, such as care	diac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Fai. ory <del>Faul</del>	lure ure					Onset and Death
	/Medical Examiner		resulting in death)		•	sequence of):						
	Examine	<u>L</u>	Sequentially list conditions, if any, leading to immediate		umonia							days
	ted sit	Examiner	Cause (Disease or injury	Due to	(or as a con	sequence of):						
	execurand and al-tran	xar	that initiated events resulting in death) Last	c	(or as a con	sequence of):						
08/60	icate be executed physician and s the burial-transit	edical		d								
POX P	attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🎖 No		tcome pf pre birth 2 🗆 f	etal death 3	□Ectopic pregnand	ру		23	d. Date of de	livery Day Year
л Э	t the c by the	hysi	9 ☐ Unknown	9□Unkn								
ecords, r	law requires that the das been signed by the 2 should be detached	þ	Part II. Other significant condition Dementia, Chi							tobacco use		the cause of death?
r	siclan; The law re certificate has bee irector, page 2 sho	Completed	Hypothyroidis	sm, Conge	stive	Heart F	ailure		_ per	opsy formed?	prior to death?	utopsy findings available completion of cause of
<u>a</u>	lan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of [	1□ Yes Death (Check only		1 🗀 1 03	2 2 10
- -	Fi his	To	1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient	2 ER/Outpatie	ent 3 DOA	her: 4X Nursin	g Home 5□Res	sidence 6	□Other (Spe	cify)
	ath. or: After thine funeral		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	of Injury oth, Day Yea	r) 28b. Time Injury	Wo	ıryat ork? ]Yes 2∐No	28d. Describe	how injury	occurred	
DIVISION	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Flace	e of injury - A ing, etc. (Sp	At home, farm, s ecify)	treet, factory, office		28f. Location City or To	(Street and own, State)	Number or R	ural Route Number,
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funera	edical	29a. Certifier 1 Certifyin (Check only one)  1 Medical	g Physician: To the Examiner: On the b and man	e best of my pasis of exar oner stated.	knowledge, dea nination and/or i	th occurred at the to nvestigation, in my	time, date and pl opinion, death o	ace, and due to the	e cause(s) a e, date and p	ind manner as place, and du	s stated. e to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	1/200	A	, /	29c Licen	se number	3	29d. Date	signed (Mant	th, Day, Year)
,	٤		30. Name and address of person of Alan Vinitsky	who completed cause M.D., 902	se of death (	lter 3a)(Type	Print) ane, #20	1, Gaith	nersburg.	2/ MD 20	0878	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4	20.10		ignature		,				
						-						

	- State Registrar	Ce	ertificate of D	eath	Re	g. No.	3 455/5
- Ed. 10	1. Decedent's Name (First, Middle, Last)			2	. Date of Death Month		3. Time of Death
Physician /Medical	John J. Shubiak			1	larch	Day Yea 1 200	
Examiner	4a. Facility Name (If not institution, give street an	d number)	4b. City, Town, or Lo			4c. County of De	
	Lorien Life Center Ass	sisted Living	Mt. Af	irv		Carrol1	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	9. E	Birthplace (State or Foreign
Director	577-56-1203 1 ¹ X ^M ²	F 66 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day Jan 30	,1942 P	Country)
	Usual Residence of Decedent					1	
ylanı ylanı at	10a. State 10b. County	10c. City, Town or L	ocation.				10d. Inside City Limits
Mar- fied fied	MD Montgomery	Gaither	sburg				1 ☐ Yes 2 🙀 No
vith the Mar t or 28a-f st be notified	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
Mit With	216 Tulip Drive		2087	7		nited Sta	
Ifter death with the Maryland Inter death with the Maryland Inter must be notified at Funeral Director	11. Marital Status 12. Was	Decedent Ever in U.S. 13.	Was Decedent of Hisp	panic Origin? (Speci			merican Indian,
tter of iner iner	1 ☑ Never Married 2 ☐ Married 1 ☐	ed Forces? Yes 217 No	. Was Decedent of Hisp If Yes, specify Cuban,	Mexican, Puerto Ri	can, etc.)	Black, W	
2-UU30 72 hours af natural", or dical Exami	3 ☐ Widowed 4 ☐ Divorced Year	Yes 2 No s, Give or Dates:	1 ☐ Yes 2 No	Specify:		Specify:	White
2 hou 2 hou cal E	15. Decedent's Education	16a. Dec	edent's Usual Occupation	on	[1	6b. Kind of Busines	ss/Industry
Medi "h	(Specify only highest grade completed in the secondary (0-12) Colleted in the secondary (0-12) Coll		edent's Usual Occupati e kind of work done dur DO NOT use retired)		1		•
Z I Z I 3-U-U ed within 72 ho ygiene. Per than "natur t, the Medical E	College College (0-12)	5+ Nuc1	ear Physic:	ist		Federal	Government
be filed tal Hyg d othe event,			1	8. Mother's Name (I	First, Middle, M	laiden Surname)	<del>-</del>
ylan yuld be Menta arked arked To B				Ann Mars	halak		
Laryiang ZIZID-UU30 2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type. Print	19b. Mai	ling Address (Street and	d Number or Rural I	Route Number.	City or Town. State	z. Zin Code)
S 0 = 7 = 0	Joan Monti / Cousin		Woodland D:				,
re, Maryla 1 and 2 should 1 Health and Men tem 27 is marke other traumatic	20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place)			Oc. Location - City	or Town, State
DESILITION  Permit. Pages Department of mportant: If it is in your injury or or once.	1 Burial 2 ☐ Cremation 3 ☐ Removal	from State Gate of		: Marcn	5		
intran influence	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenage		22. Name and Address	2008		Silver S	pring, MD
Datumore, permit. Pages 1 an Department of Heal important: If Item 2 any Injury or other once.	Martin & Day	I			10 East	t Deer Pa	rk Drive
-	23a Part I Enter the disease or complication	that assumed the death. Do not or	DeVol Funer Gait	hersburg,	, MD 208	877	Approximate
-	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one calls of	on each line.				Sī,	Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)		Wholshais	31 Tuton	char		Minutes
/Medical Examiner	Di	ue to (or as a consequence of):		0.2			,
	Sequentially list conditions, if any, leading to immediate b.	ue to (or as a consequence of):					
ed sit	cause. Enter Underlying Cause (Disease or injury	le to (or as a consequence of).					
executed executed in and ital-transit Examines	that initiated events c	le to (or as a consequence of):					
be es ciclan buria		to to to. do a consequence of.					
certificate be executed certificate be executed anding physician and use as the burial-transit	d						
certification and inguise as	IF FEMALE:	a cutooma of programmy					
ath cath contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of the contact of t	230. Was decedent pregnant		☐Ectopic pregnancy			23d. Date of 6 Month	delivery Day Year
hat the death d by the atteletached for Physicia	1 Yes 2 No 9 Unknown 9 Unknown	Pregnant at time of death 5 Unknown	Other (specify)				,
The law requires that the death ate has been signed by the atter bage 2 should be detached for completed by Physician	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given	in Part I	23a Did tob	acco use contribute	to the cause of death?
ires t		to deal but not resulting in the	underlying cause given	iii t ait i.			
The law requires: The law requires cate has been sign, page 2 should be Completed by					1 Tes	s 2	Probably 4 Unknown
law las b					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of ?
The The page					perform	led2 death	? es 2 No
iclan: certific ector,				26. Place of Death (			
hysic this ca all dire	1 Yes 2 No Hospital:	1   Inpatient 2   ER/Outpatie	ent 3 DOA Other:	4 Nursing Home	5 🗆 Resider	nce 6 Other (S	pecify)
ng Phy neral chi	27. Manner of Death 1 Natural 5 □ Pending	Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury a Work?			w injury occurred	
Attending r death. ector: Afte by the fune fification	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,		es 2 □ No			
recta	3 Suicide 6 Could not be determined 28e.	Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28	f. Location (Stre City or Town,	eet and Number or	Rural Route Number,
Ital or Attending F rs after death. ral Director: After led in by the funers Certification:					ony or rown,	<i>C.a.o,</i>	
lospi hour uner bly fill		o the best of my knowledge, dea	ath occurred at the time	, date and place, an	d due to the ca	use(s) and manner	as stated.
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for Medical Certification: To Be Completed by Physician		manner stated.			acuse usite, da	no anu piace, and (	ade to the cause(s)
To t To t Com	29b. Signature and title of certifier	2/1/1.	29c. License n	_		d. Date signed (Mo	
12	· Xang	J G CM)	10005	9943		March 3	12008
	30. Name and address of person who ompleted	cause of death (Item 23a) (Type	e, Print)			10	
	Jann Maer m	Zas Spury	R. Svipe	39 V	ves mir	15/2/ MC	2112)
State	31. Date filed (Month, Day, Year)  MAR 0 4 2008	32 Registrar's Signature	. 6.0			,	
Registrar	MAR 0 4 2008	The Course St. All	340				

		1 - State Registrar	le oi Mai	-		icate of D		ental Hygic Rec	_{a. No.} 200	08679		
Physician /Medical		1. Decedent's Name (First, Middle, Last)  ARVENIA H. SLADE					2. Date of Death Month Feb. 23	3, 2008	3. Time of Death 2:30A M			
Examin	er	4a. Facility Name (If not institution, give street a Montgomery General	tal	4b	o. City, Town, or L Olney	ocation of Death		4c. County of D	gomery			
Funeral Director		5. Social Security Number 237-18-0017 6. Sex 1 M 2	M 2 XF 7. Age (In yrs. last birthday) 91 Yrs.			Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov • 22	(ear) 1916 N	Birthplace (State or Foreign Country)  Orth Carolin		
filed within 72 hours after death with the Maryland Hygiene. https://www.natural., or items 23a or 28a-f show sht, the Medical Examiner must be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  NC Edgecombe		0c. City, Town	or Location		10d. Inside City Limits 12⊈Yes 2 □ No					
	al Director	10e. Street and Number 419 Albermarle	per 10f. 2					10f. Zlp Code 10g. Citizen 27801 U.				
	by Funeral	Arried 2 Married 1 ☐ Never Married 2 Married 1 ☐ Y	s Decedent Evened Forces?  Yes 20 No es, Give ar or Dates:			Decedent of Hises, specify Cuban Yes 2 XNo	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, \	e - American Indian, sk, White, etc. :: Black		
d within 72 hou giene. er than "natura the Medical E	Completed	15. Decedent's Education (Specify only highest grade comp	nly highest grade completed)			's Usual Occupat d of work done du NOT use retired)	tion uring most of worki	ing 1	ess/Industry			
be od o	To Be Co	17. Father's Name (First, Middle, Last)  John Hagan		7010								
nd 2 suith au 27 is r trau								Rural Route Number, City or Town, State, Zip Code)				
permit. Pages 1 a Department of Hes Important: If Item any Injury or othe	_	20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☑ Remova 4 ☐ Donation 5 ☐ Other (Specify)  21. S	oc. Location - Cit Rocky M uneral	Mount, NC 1 Home, PA 1e, MD 20850								
ifficate be executed  By Medical  Examiner  By the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Hypertension  Due to (or as a consequence of):  Due to (or as a consequence of):										
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes							23d. Date of delivery  Month Day Year			
	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknow				
ine law re cate has bee page 2 sho	Completed	24a. Was autor perto 1 ☐ Yes										
r Attending Physician: er death. irector: After this certific i by the funeral director,	o Be	25. Was case referred to medical examiner?  26. Place of Death (Check only one)  Hospital:										
	Certification: T	27. Manner of Death 1										
Hospital (24 hours at Funeral D) Funeral D) stely filled in	edical Cer	29a. Certifier  (Check only one)  1 **X*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the within comple	Med	29b. Signature and title of certifier  D6 5 9 1 5  Peb.								23, 2008		
St	ate	30. Name and address of person who complete Chuanbo Zhang, M  31. Date filed (Month, Day, Year)	D 8609	Seco	nd A	ve #40	4B Silv	er Spri	.ng, MD	20910		
Regist		MAR 0 4 2008	Beneux.	s signature	Span	a						

DHMH 17 Rev 1/2001

08-01766	
Jermaine Tinch	

rmaine Tinch		I- For State	of Maryland /		rtment of tificate of			Menta	al Hyg		g. No.	200	18	0868	
Physicia	an/	Registrar							2.	Date of Deat		Year		ime of Death	
ledical Examiner		JERMAINE L. TINCH 4a. Facility Name (if not institution, give street and number)					March b. City, Town, or Location of Death					County of Dea		0414 hrs	
									Prince George's						
Funeral		5. Social Security Number 6. Se	ex 7. Age	(In yrs. la	st birthday)	If Unde					,	D/YYYY) 9. B	irthpla	ce (State or	
Director		579-08-3602	M 2 F		23 _{Yrs.}	Months	Days	Hours	Min.	APRIL	12,	1984	ountry	WASHINGTON D.C.	
any		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Location	on					_		100	. Inside City Limits	
* *	_	MD PRINCE (	GEORGE'S	CLI	NTON								1	χ Yes 2 No	
Aaryland 28a-f show 1 at once.	ecto	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cour							untry?						
h the Maryland 3a or 28a-f sho	ġ	6706 KILLARNEY ST.				20735						UNITED STATES			
ith with terms 2 st be n	Funeral Director	1 V Never Married 2 Married Armed Forces?				<ul> <li>Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ul>					o- 14. Race - American Indian, Black, White, etc.				
iter des								Specify: BL	ΔCK						
ours a latura	d b	15. Decedent's Education (Specify o	Lor Dates: nly highest grade comp	oleted)	16a. Decedent	's Usual (	Occupatio					ind of Busines		stry	
36 in 72 h nan "n lical E	plete	Elementary/Secondary (0-12)	College (1-4 or 5	+)			_		30 10010	۵)		DD TX (A m	В		
215-0036 be filed within 7 ttal Hygiene. ked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last	2		1	LANDS			Name (I	First, Middle, I		PRIVAT Surname)	<u> </u>		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medial	Be														
	욘	19a. Informant's Name/Relationship (TGEORGE A. BOOMER)	• • • • • • • • • • • • • • • • • • • •				•					y or Town, Sta		Code)	
and 2 sho lealth and tem 27 is traumati		20a. Method of Disposition			Place of Disposi	ition (Nan	ne of ceme			INTON,		.ocation - City		n, State	
altimore, mit. Pages I at spartment of Het sportant; If ite		1 Burial 2 Cremation 3			rematory or oth			FRY	3/7/	N8		INTON	MD		
Baltir Departme Importan njury or		RESSURECTION CEMETERY 3/7/08 CLINTON, MD.  21. Signs ture of Funeral Service Licensee  22. Name and Address of Facility  D.C. 20002													
	10	June you	your for	-										.E. WASH	
Physician /Medical	8 (%	23a. Part I. Enter the disease, or comparing failure. List only one (a se on e	ach line.		V	ne mode d	r ayıng, s	uch as car	rdiac or i	espiratory an	est, sno	ck, or neart		pproximate Interval Between Onset and Death	
xaminer		Immediate Cause (Final discase a or condition resulting in death)	Gunshot Wound  Due to (or as a conse	_									-		
-	_	Sequentially list conditions, but fany, leading to immediate Due to (or as a consequence of):													
	Examiner	if any, leading to immediate Due to (or as a consequence of):  rause Enter Underlying Cause (Disease or injury that initiated													
cuted and transit		events resulting in death) Last Due to (or as a consequence of):													
× = -	edical	UNPENDED	AMENDED												
760, icate be opposited the physicial	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregr	nancy							. Date of deliv	-		
Ox 6876(eath certificate attending physon for use as the b	sician/M	past 12 months?	1 Live birth Pregnant at	time of de	oth -	tal death her <i>(</i> Spe	3 ∟ cifv)	Ectopic	pregnan	су	4	Month	Day	Year	
Box ne death c the atten	Physi	1 Yes 2 No 9 Unknow	9 Oliknown							Leo Bill		<del></del>			
Division of Vital Records, P.O. Box 6876.  Hospital or Attending Physician: The law requires that the death certificate 24 hours after death.  Funeral Director: After this certificate has been signed by the attending phytely filled in by the funeral director, page 2 should be detached for use as the b	by	Part II. Other significant conditions	contributing to death	but not re	esulting in the u	inderlying	cause gr	ven in Par	t I.		_			cause of death? y 4 Unknown	
ds, equire een sig	Completed									24a. Was				sy findings available	
Records,  The law require ficate has been si	ldmo		<del></del>		<del></del>					auto perfo	rmed?	death	?	pletion of cause of	
Vital Rec ysician: The l his certificate l	Be Co	25. Was case referred to medical					26.Place	of Death (0	Check or			9 1	163		
Of Vital ng Physician After this cert neral directo	To B	1 ✓ Yes 2 No			ER/Outpatient		<u> </u>			Home 5	Reside		her:		
n of ding Ph h. After t funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Day Yo Mar 2, 2008	ry ear)	28b. Time of I 0339 hrs	njury :		/ at Work?		28d. Describe Subject sho		ary occurred			
Division tal or Attendir is after death. In Director: A led in by the fu	icati	2 Accident Investigation 28e Place of Injury - At home farm s					1 Yes 2 V No				28f. Location (Street and Number or Rural Route Number, City				
Divi	Certification:	Suicide 6 Could not be determined (Specify) Major Road / Highway								State) and New York Avenue, Washington , DC					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										ause(s)			
To the within 2 To the complet	Medical	29b/Signature and title of certifier  29c. License number  29d. Date signed (Mo													
6		( ( A sa bite of W)										March 2, 2008			
3/		3 Name and address of person who completed cause of death (Item 23a)													
AC	Š		stant Medical Exa		111 Penn	Street	, Baltim	ore, MD	2120	)1 					
S Regis	tate trar	31 Date filed (Month, Day, Year)	32. Registral	's Signatu	ire										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Month Physician March 2008 1:00p M Samuel Franklin Trivett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital Ceci1 E1kton 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign March 28, 1955 VA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 □ F 216-66-6605 Director 52 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r 28a-f show notlfied at Director 1 XYes 2 No Ceci1 E1kton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 19 Bratton Rd. U.S.A. "natural", or Items 23a 21921 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1X Yes 2 No If Yes, Give 1973 – Year or Dates: 1975 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify. White Specify: ģ 3 ☐ Widowed 4X Divorced 1975 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) nd Mental Hygiene. marked other than Welder Amtrak fled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h Be and 2 should be Garney Trivett ဂ္ Myrtle L. King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle Trivett/Mother Bratton Rd., Elkton, injury or other Date of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans

Manage Date 20a. Method of Disposition 20c. Location - City or Town, State Pages ō 1 Usurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Glasgow, DE Cemetery
22. Name and Address of Facility 21. Signature of tup tal Selvice Licensee Andrew G. Gee Funeral Home 259 E. Main St., Elkton, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nutic disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the death certificate be executed the burial-trar Due to or as a consequence of Division or Vital Records, P.O. Box 68760, attending physician use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed? certificate 1 ☐ Yes 2 ☐ No 201 Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 Ampatient 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 2009

State Registrar

MAR 0 5 2008

Year)

Ryti

123 Singer

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Kathryn 2207M March 5 2008 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington

9. Birthplace (State or Foreign Country) Hagerstown If Under 1 Year | If Under 24 Hrs Washington County
5. Social Security Number 6. Sex Hospita 8. Date of Birth (Month, Day, 1 □ M 2 🛛 F Months Days Hours 94 19 1913 Sept. Maryland 214-14-6545 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20009 Rosebank Way Apt. 107 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: 3 X Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Motorcycle 8 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Oscar George Warrenfeltz Bessie Catherine Koogle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mike Twigg - Grandson</u> 20337 Ayoub Lane, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3/8/08 Rest Haven Cemetery Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lic Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final MERMONIU -4 DAY disease or condition resulting in death) Due to (or as a consequence of): HMONIC OBSTRUCTIVE LONG DISERSE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ONGESTIVE Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Completed by Funeral

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anones.

Baltimore, Maryland 21215-0036

and the burial-tra physician use as attending for use as sate has been signed by the a page 2 should be detached to certificate funeral director, After n 24 hours after death.

he Funeral Director: Af

The law requires that the death certificate be executed

or Attending Physician:

Hospital

Division or Vital Records, P.O. Box 68760,

Examiner

by Physician/Medical

Be Completed

Certification: To

Medical

				1 ☐ Yes 2 ☐	No 3 Probably 4 Nunknown
				24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 🐧 No	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐!	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	3 ☐Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, factify)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
29a Certifier 1 Certifying P	hvsician: To the best of my kr	owledge, death occurre	ed at the time, date and place	ce, and due to the cause(s)	and manner as stated.

29a. Certifier (Check only one)		wledge, death occurred at the time, date and place, and due ion and/or investigation, in my opinion, death occurred at th	
OOL Cianoture on	ed title of cortifier	29c License number	29d Date signed (Month Day Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CADIA

HMGENSTOWN MD 21740 1190 NOM) ALTWA

D46561

03,05.2008

Registrar

completely filled in by

within 2

5H-3

31. Date filed (Month, Day, Year)

GUMANA

32. Registrar's Signature

MAR 0 2008 Certificate of Death

2. Date of Death

1. Decedent's Name (First, Middle, Last)

Month **Physician** 2008 5.209,M Gertrude Elizabeth Truesdale /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 8. Date of Birth (Month, Day, Yea Oct 31, 1 9. Birthplace (State or Foreign Virginia 10d. Inside City Limits 1X Yes 2 No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Specify: Black 16b. Kind of Business/Industry Healthcare 18. Mother's Name (First, Middle, Maiden Surname) Minnie Gertrude Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19041 Sedley Terrace Gaithersburg, MD 20879 20c. Location - City or Town, State Beltsville, MD Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of perform death? 1 ☐ Yes 2 □ No 1☐ Yes 2 NO 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 3-4-08 30. Name and address of person who co 50m 31. Date filed (Month, Day, Registrar's Signature State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland / i		rtificate of		, ,	giene Reg. Nd.		08681
	Physici	an	1. Decedent's Name (First, Middle, La	Ť.					2. Date of Dea	ath	LUUU	3. Time of Death
	/Medic	cal	RIT 4a. Facility Name (If not institution, giv		N TH	IOMA		r Location of Death	02 Month	25	Year 08	8:30 A M
	Examir	ier	WMHS-BRADDOCK C				CUMBERLA				LLEGANY	
7	Funeral Director		5. Social Security Number 6. S 215-20-6916 Usual Residence of Decedent	Sex 7. Age I□M 2XIF 8.	(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 05/21/	y, Year)	9. Birt Co Mar	hplace (State or Foreign untry) yland
	yland how at		10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	ne Mai 8a-f sl otified	ector	MD Allega	ny		Cum	berland					1 ☐ Yes 2 M No
	ath with the same same same same same same same sam	Funeral Director	10e. Street and Number 12813 Thurmel		-			21502			izen of What Co USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2∑ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:	
5-0	רא 27 ה "natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a	(Give	dent's Usual Occup kind of work done OO NOT use retired	durina most of work	ing	16b. Ki	ind of Business/	Industry
212	y withir giene. r than the M	ошо	Elementary/Secondary (0-12)	College (1-4or 5-	+)		nemaker	1)			Home	
nd	oe filec tal Hyg d othe svent,	BeC	17. Father's Name (First, Middle, Last		~ -			18. Mother's Name			,	
Maryland	d Men marke natic	٩	Millard  19a. Informant's Name/Relationship	Russell			er, Sr.	Gertru and Number or Run			abeth	Bartik
	nd 2 si alth an 27 Is r r traur		James A. Thomas				-	and Number of Hur. 1 Drive,				,
ore,	es 1 a of Hea filtern ir othe		20a. Method of Disposition 1  ☐ Burial 2 □ Cremation 3 □	Removal from State	20b. Place o	of Dispos	sition (Name of matory or other place	1 [	Date		ocation - City or	
Baltimore,	it. Pag rtment rtant: I njury c		4 ☐ Donation 5 ☐ Other (Special	ý)	MD Vet			y Gap 02/			lintsto	
Bal	permi Depa Impo any Ir	S. 1	21. Signatur of Fineral Service Lice	adam	28			ss of Facility Ada ir Street,				Home, P.A. 21502
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused tone cause on each line	the death. Do		er the mode of div	ng, such as cardiac		rest,		Approximate Interval Between Onset and Death
6 4	Examiner			Due to (or as a	cons uence	of):	1					. (
	ed sit	iner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	cunsequence	of):						
Ć.	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):						
68760,	ate be hysicia he bur	edical		<b>_</b> d								
	certifica ding pl	/Ме	IF FEMALE:	23c. If yes, outcome p	of pregnancy					-1		
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal death		Ectopic pregnancy Other <i>(specify)</i>				23d. Date of del Month	Day Year
rds, P.	n requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but	t not resulting i	n the ur	nderlying cause giv	en in Part I.	23e. Did to			the cause of death?
Division or Vital Records,	slclan: The law ra certificate has be irector, page 2 shu	Completed							24a. Was a autop perfor	sy rmed?	prior to death?	topsy findings available completion of cause of
Zii:	slclan certifi irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ıt 2□ER/Oı	.tnation	Oth	26. Place of Death				
٥٢	ig Phy ter this neral d	n: To	27. Mann of Death	28a. Date of Injury (Month, Day	/ 28b.	Time of Injury	I S DOA	4 ☐ Nursing Ho	me 5 ☐ Resid 28d. Describe h		6 □Other (Spec ry occurred	cify)
sior	tendin eath. tor: Af the fur	catio	1	1			M 1 🗆	Yes 2 □ No				
Ω	tal or At s after d al Direct ed in by	Certification:	4 Homicide determined	28e. Place of injur building, etc.	ry - At home, fa ( <i>Specify</i> )	arm, stre	eet, factory, office		28f. Location (S City or Tow	Street an vn, State	nd Number or Au e)	ıral Route Number,
	To the Hospital or Attending Physician: The within 24 buts after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical (	(Check only 2 Medical Exal	nysician: To the best of miner: On the basis of and manner state	examination ar	e, death	vestigation, in my o	ppinion, death occur	red at the time,	date and	d place, and due	to the cause(s)
		2	29b. Signature and title of certifier	more	m		29c. Licens	e number	1	1	te signed (Monti	1 2000
,	5		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, I	Print)	0 1	1 1		4 My d	o swo
	N LS		31. Date filed (Month, Day, Year)	er 925 K	SiSNOP	Wal	sh Drive	-, Camb	erland	, Ma	ryland	21502
	Sta Registr		FEB 2 6 2	008	a B	B	corde					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08685 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mar 7, 2008 6:43pm Ullery Odessa /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland Devlin Manor Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 3, 1917 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min 1□M 2√F Director 214-36-6790 91 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany Cresaptown ¹¥ Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 14910 McMullen Hwy USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 □ Xo Specify. Specify: Completed by 3 X Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u> 12</u> Board of Education Cresaptown School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Luther "J.L." Shanholtz Delsie (Moreland) Shanholtz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any Injury or other trau 13715 Brant Road **Edward Ullerv** Cresaptown MD 21502 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Salem Un. Methodist Ch. Cem 3/12/2008 Slanesville WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Frieral Service Doens 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Corona disease or condition resulting in death) /Medical Due to (or as a c n equence of): Examiner Sequentially list conditions, if any leading 15 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown Month Year Day 5 Other (specify) the the P.O. signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 21 No 3 Probably 4 Unknown 1 TYes 24a. Was an autopsy performed? 1□ Yes 2♣ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 page certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) hours after death. uneral Director: After th ly filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Vithin 24 hours and To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 29c. License number 1) 00 33 280 Zelup

DHMH 17 Rev 1/2001

State Registrar AVE - CUMBERLAND, MD 21502

30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Q2

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland / Depa			Mental Hyg	jiene		
			Registrar		Ce	rtificate of	Death		eg. No.	2008	08685
nijs.	Physici	an	Decedent's Name (First, Middle, Last	,				2. Date of Dea Month	Day	, 2008	3. Time of Death
	/Media	al	Elsie Evelyn Vice			4h Cihi Toum a	a Lagation of Deat	Februar			4:07 P M
	Examir	er	4a. Facility Name (If not institution, give Anne Arundel Medi			Annap	r Location of Deat	n	4c. County of Death  Anne Arunde1		
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		1	9. Birt	hplace (State or Foreign
	Director		214-24-4615	□м 2ХО F 79	Yrs.	Months Days	Hours Min.	(Month, Day 8/07/19	, <i>Year)</i> 928	Co	untry) entucky
	PL ,		Usual Residence of Decedent	1	10.00						
	aryla show	<u>_</u>	10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limits 1 □ Yes 2 X No
	the M 28a-f otifie	Director	Maryland   Anne Ar 10e. Street and Number	undel	Arnol	d 10f. Zip Code			On Citiz	en of What Co	
	with a or the n	اقًا	431 Manor Rd.				.012		og. Giliz	USA	uritry ?
	ns 23 mus	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13,	Was Decedent of H		Specify Yes or No-	1	4. Race - Ame	rican Indian,
က	or iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ▼ No				to Rican, etc.)		Black, White	e, etc.
Ö	ral", c	l by	3 Midowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			Specify: W	hite
21215-0036	72 h 'natu die i	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most of wo	rking	16b. Kin	d of Business/	Industry
121	vithin the. than '	Idu I	Elementary/Secondary (0-12)	College (1-4or 5+	)		d) -			***	
5	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medir A Examiner must be notitied at		12th 17. Father's Name (First, Middle, Last)		, п	omemaker	18. Mother's Na	me (First, Middle, i	Maiden S	Home	
an	d be ental	o Be	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	l Whitaker				lsie Eli:			11
Maryland	2 should by and Ment is marked raumatic e	ပ္	19a. Informant's Name/Relationship (		19b. Maili	ng Address (Street					
	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Kenneth L. Blacky	e11/ Son	284	Greenlea	f Circle	, Arnold	, MD	21012	
ore,	of He of He litem		20a. Method of Disposition	Danas and from Chats	20b. Place of Dispo cemetery, cre-					ation - City or	Town, State
Baltimore,	permit. Pages Department of I Important: If ite any Injury or or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Specif</i> y			st Cemete		/08	Ann	apolis,	MD
ä	permit. Pag Department Important: I any Injury o		21. Signatur of Funeral Senice Licer	see	22	2. Name and Addre	ess of Facility G	eorge P.	Kala	as Fune	eral Home
_	20 E 2 3		I af on f all			2973 Solo				water,	
Н			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused to one cause on each line	he death. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
綇	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		cerebra	1 nen	norna	10			minutes
	Examiner			Due to (or as a	consequence of):		~				
	<b>6</b> , 9,	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or es a	оспансиновновнов						
	outed Id ansit	Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
oʻ	an an irial-tr	E	resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate be executed physician and the burial-transit	dical		.d							
ي م	ertific ling p		IF FEMALE:								
Bo	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnanc	y		2;	3d. Date of del Month	ivery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4⊟Pregnant at t 9⊟Unknown	ime of death 5 L	Other (specify) _					
Vital Records, P.O. Box	n requires that the di been signed by the should be detached	by Physician/Me	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
rds	quires n sigr ald be	q p						1 □ Y	es 2	]No 3∏Pr	obably 4 Unknown
S	sw rec	Completed						24a. Was a	ın	24b. Were au	topsy findings available completion of cause of
æ	The lav	om						autops perfor	sy med?	prior to death? 1 ☐ Yes	
ţa	ician: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Place of De	1  Yes ath (Check only on	2, <b>27</b> (No	1 🗆 1 es	2[]140
>	Physic this ce al direc	To E	examiner? Yes 2□ No	Hospital: Inpatien	t 2 🗌 ER/Outpatie	nt 3□ DOA Ott	er: 4 ☐ Nursing I	Home 5 ☐ Reside	ence 6	☐Other (Spec	cify)
0 _	ng Pl	Ë	27 Manner of Death  Natural 5 □ Pending	28a. Date of Injury (Month, Day		of 28c. Inju Wo	ry at rk?	28d. Describe he	ow injury	occurred	
Division or	Attending Physician: or death. ector: After this certific by the funeral director,	catic	2 Accident investigation 3 Suicide 6 Could not be	F			Yes 2 □ No				
$\overline{\leq}$	I or Attending I after death. Director: After I in by the funer	Certification:	4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, farm, sti (Specify)	reet, factory, office		28f. Location (Si City or Town		Number or Ru	ural Route Number,
	spital or ours afte eral Dir filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, deat	th occurred at the ti	me_date and plac	e and due to the o	ause(s)	and manner as	stated
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as a	Medical	(Check only one) 2 Medical Exam	niner: On the basis of and manner stat	examination and/or ir	nvestigation, in my	opinion, death occ	urred at the time, o	date and	place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	10	29c. Licens		2		signed (Mont		
	n.		Jain well	ness x		0	57078		2	-29-	2008
•	10 COM		30. Name and address of person who								
	12/1/2		Jacqueline Susan			dical Pkw	y., Anna	polis, M	D 21	401	
	Sta		31. Date filed (Month, Day, Year)	32. Renstrai	s signature —	don't .					

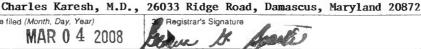
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔡 🔝 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 27 7:55 p^M Charles Vest February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner The National Lutheran Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 **3** M 2 □ F Yrs. April 13, 1923 Director 84 West Virginia 234-22-1440 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10h Counts 10c. City, Town or Location 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2KNo Director Silver Spring Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "--- eny injury or other traument." ö Items 23a 13604 Fairridge Drive 20904 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 T Married If Yes, Give Year or Dates: WWII 1 Yes 2 No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Material Scientist & Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Bert Benson Vest Gladys Opal Hall 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Vest - Wife 13604 Fairridge Drive, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 03/07/2008 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc Funeral Service Licensee 21. Signature 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death P.O. | 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but polyresulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No 2 No After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dee. 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License numbe vary 28,2008 arech

State Registrar

31. Date filed (Month, Day, Year) MAR 0 4 2008

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For 3-5-08 State of Maryland / Department of Health Registra Amend#'s 16a. 19b. Per Informant POCT Certificate of Death 12685 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Watson Year Physician 11:40 AM avolun February 2008 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore C1+~ Hopkins he Johns Baltimore if Under 1 Year | if Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 反 F 53 Director 5/22/1954 Wash. D.C. 579-74-4264 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. inside City Limits 10a. State 10b. County 10c. City, Town or Location ty⊡Yes 2 No Funeral Director Maryland | Charles Bryans Road 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20616 United States 6982 Heather Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No ò 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Administrative Support Specialist Elementary/Secondary (0-12) College (1-4or 5+) 12 Analysis Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Brady Graham Dorothy Miner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8510 Waco Drive, Ft. Washington, Md. 20744 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dena Strong / Daughter 20a. Method of Disposition Date Wash D.C. 20032 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 3/3/2008 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. M00991 Charles 5538 Marlboro Pike Forestville, Md. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovascular collapse **Physician** 48 hours /Medical Due to (or as a consequence of): **Examiner** 30 years Cardionzopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Physician signed by the attending physician and be a signed by the attending physician and burial-trar Due to (or as a consequence of) Physician/Medical 23c. if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Division or Vital Records, P.O. Box 68760,

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier

To the within 2 State Registrar

MAR 0 5 ZUU8

29c. License number RES-000

29d. Date signed (Month, Day, Year) February, 25, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe Street, Bultimore, Maryland Benjamin Steinberg

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

سَي		1 - State Registrar Amended # 8  1. Decedent's Name (First, Middle, Last		3/5/08 <i>Cel</i>	rtificate o	f Death	2. Date of De	Reg. No.	3. Time of De
Physici		Ellen M. Ward					03/03,	/2008	Year 5730
/Medic		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Deat	h	4c. County of	of Death
		11654 Norris Tw	illey Road		Mard	ela Sprin	gs	Wio	comico
Funeral Director		J10-J2-1311	x 7. Age (// □M 2—∏ F	n yrs. last birthday) 68 Yrs.	If Under 1 Year Months Day			th, Year) 1 <del>937</del> 1939	9. Birthplace (State or Fo Country) Washington D
*		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or Lo	ocation			1939	10d. Inside City L
8e-f eho	ector	MD Wicomic			la Spri				1 Tes 21
23a or 2 uni be n	rai Dire	10e. Street and Number 11654 Norris Twil	ley Road			21837		10g. Citizen of W	A
of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23s or 28e-f ehow or other traumatic event, it a Medical Exarta set must be rediffied at	Completed by Funeral Director	11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	ł	Was Decedent o If Yes, specify Cu 1 ☐ Yes 2 📉 N	f Hispanic Origin? (Suban, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	14. Race Black Specify:	White
ene. than "natu ta Medical	ompieted	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti uet mana	ne during most of wo red)	rking	16b. Kind of Bus	
and Mental Hygiene. is marked other than aumatic event, Ita Mi	To Be Co	17. Father's Name (First, Middle, Last) Thomas Madigan				18. Mother's Nar	ne (First, Middle elen Da	l , <i>Maiden Sum</i> ame Ly	a)
aith and Men 27 is marke er traumatic	-	19a. Informant's Name/Relationship (7) Maureen C. Starg				et a <i>nd Number or Re</i> brook Lan			
nent of He int: If Item iry or oth		20a. Method of Disposition  1 ★Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo cemetery, crer Mt. Oliv	matory or other p	LALC	pate ch 6, 008	20c. Location - 0 Washingt	City or Town, State
Department of Health ar Importent: If Item 27 is any injury or other traugons.		21. Signature of Funeral Service Licens		22	Name and Add			neral Hor MD 2071	ne o
nysician		23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the ne cause on each line.	e death. Do not ent		ying, such as cardia	or respiratory a	rrest,	Approximate Interval Betwee Onset and Dea
Medical xaminer		resulting in death)  Sequentially list conditions	Due to (or as a co	onsequence of):					
nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):					
hysician and he burial-transit	cal	resulting in death) Last	Due to (or as a co	onsequence of):					
ed by the attending physi detached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of particles of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec	Fetal death 3	Ectopic pregnar Other (specify)	icy		23d. Date Mon	e of delivery tth Day Yea
been signed t	þ	Part II. Other significant conditions co	ntnbuting to death but n	ot resulting in the u	nderlying cause	given in Part I.			bute to the cause of deat 3 <b>X</b> Probably 4 □Unki
ate has page 2	Completed						24a. Was auto perfo	psy promed? d	Vere autopsy findings ava rior to completion of caus eath? ☐ Yes 2 ☐ No
	Be	25. Was case referred to medical examiner?	lospital:		_ [	ther	ath (Check only		
h. Atter this funeral di	lon: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. In	ury at ork?		dence 6 Othe	
offer deal	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, str Specify)		Yes 2 No	281. Location ( City or To		or or Rural Route Number
n 24 hours a	edical		sician: To the best of m ner: On the basis of ex and manner stated	amination and/or in					
complet	W	29b. Signature and title of certifier				1+50497		29d. Date signed 3 /4 \ 08	(Month, Day, Year)
if e		30. Name and address of person who co		(Item 23a) (Type, ECurvo)		Salishu		0 .	

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No .-2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March Robert Francis Wagner 2008 15:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F Yrs. 217-62-3632 53 1955 Pennsylvania Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow rthan "naturel", or Items 23a or 28a-f eho the Medical Examiner must be notified at 1 XYes 2 □ No Funeral Director Maryland Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1327 Superior Street 21078 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 ☐ Widowed 4 🛣 Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Business Owner permit. Pages 1 and 2 should be filed to Department of Health and Menial Hygie Important: If item 27 is marked other t. eny injury or other traumatic event, Impore. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oscar F. Wagner Sophie Harovin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Zellman (Sister) 1327 Superior Street Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 3/8/2008 Bel Air, Maryland 22. Name and Address of Facility Zellman Funeral Home, P. A 21. Signature of ameral Service License 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Just only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) empyema **Physician** /Medical Due to (of as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Tes To the Hospitel or Attending Physician: with n 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 □ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Contifying Physician: To the least of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner at stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiers D0063220 2008 30. Name and address of person who completed cause of death. Item 23a) (Type, Print) GEO RGE 31. Date filed (Month, David Par) State Registrar

WASNER, KOBER

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 200<u>8</u> March 10, Physician Claude Allen Webb 6:40 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 823 C Stratford Drive Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1XM 2□F Yrs Director 220-28-3010 27, 1931 Maryland 76 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director Frederick Maryland Frederick 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 823 C Stratford Drive 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 carpenter <u>home building</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Webb ဥ Amanda Jane Willis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Webb/ wife 823 C Stratford Dr., Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery |03/15/2008 | Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford PA, Funeral Home lu / MO1222 106_East_Church_Street, Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Obstructive Pulmonar Discare Chronic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): DAYS Examiner Sepsus if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 **□** No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check or one) and manner stated. 29b. Signature ar 00062223 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) , 196 TJ DLIVE, FLEDENCE, MO-LMEZ HD PLAYEEN BI CALUT

G DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** William Leroy Youngblood, Sr. FEBRUARY 2008 10:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY **CUMBERLAND** MEMORIAL HOSPITAL Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F 218-16-4123 82 03/07/1925 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Cumberland 1 ☐ Yes 2 ☐ No Allegany Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12109 Shadoe Hollow Road 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 6 <u>Carpenter</u> <u>Construction</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leslie Youngblood Ι., Blanche Ivadeen Willison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christopher E. Youngblood / Son 12109 Shadoe Hollow Road, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Fairview Christian Cem. 03/03/2008 Inglesmith, PA 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Lice doing 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part . En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician day disease or condition resulting in death) /Medical Due to as a consequence of): Examiner 460mic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examine all Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform 2 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 5+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 902 SETON DRIVE, CUMBERLAND, MD 21502 AHMAD, AFAQ, M.D.,

Registrar

State

31. Date filed (Month, Day, Year)

FEB 2 8 2008

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Marc Antis 2008 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sa uare ital a 8. Date of Birth (Month, Day, Year) January 30, 1920 9. Birthplace Country) Ohio yrs. last birthday) if Under 1 **Funeral** Hours Months Days 1 XM 2 ☐ F 88 296-16-7499 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Internation of thems 23a or 28e-f show Important: if flem 7 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 7448 Edsworth Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [ŽYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White þ 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Boat Repairman Boat Yard 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Underwood Earnest Antis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2907 Yorkway Apt A., Dundalk, Maryland 21222 Daughter Christa Panoni 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 19. 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery Baltimore, Maryland 2008 4 Donation 5 Dother (Specify) 21. Signature of Fyneral Service Licensee Conneil Votantal Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medicai Cellularitis Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and a Due to (or as a consequence of): physician ar Box 68760, Physician/Medical ası aftending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 1 ☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No ρ Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached f the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy perform page certificate 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA 2 1 Inpatient After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

P.0. Records, Division or Vital the Hospital or Attending within 24 hours after deam.

To the Funeral Director.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who complete

Year.

2008

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

in Square Drive Baltimore, Ud

1_	For State Registrar
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		•	1 - For State Registrar	State of Marylana	Certificate of Death	Reg.	No.
			Decedent's Name (First, Middle, I	Last)		2. Date of Death Month	Day Year 3. Time of Death
W.	Physici /Medic	_	Florenc	e M. De	-ll	03 1	6 2008 0208m
	Examin		4a. Facility Name (If not institution, g	give street and number)	4b. City, Town, or Location of E		4c. County of Deeth
	*		MANORCANE /	Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	BACTIAINE CITY
	Funeral Director		5. Social Security Number  225-30-36/2  Usuel Residence of Decedent	1 M 2 X F 7. Age (in yis. las		Min. (Month, Day, Ye	
	land ow		10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits
	Mary L-f eh	to	MD N/A	Bal	timore		1 X Yes 2 □ No
	sth with the Marylan 23s or 28s-f ehow	Funeral Director	10e. Street and Number 3600 W. Frank	lin Street	10f. Zip Code 21 2 0 1	10g.	Citizen of What Country? USA
5-0036	or Items	by	11. Marital Stetus  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give ↑ Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify frican  American
2-0	72 hours	eted	15. Decedent's (Specify only highest of	Education grede completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of	of working	. Kind of Business/Industry
2121	i within iene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)  Laborer		Hospital
Maryland	ed its b	To Be (	17. Father's Name (First, Middle, La Matthew Smit			s Name <i>(First, Middle, Meid</i> er Smith	den Sumeme)
ary	s 1 and 2 should be f Health and Mental item 27 ie marked o other traumatic ev		19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number of		•
	D=21		Janice Montgor		3016 Spaulding A		
Baltimore,	00	F	20a. Method of Disposition  1 ☑ Buriel 2 ☐ Cremation 3  '4 ☐ Donetion 5 ☑ Other (Spe	□Removal from State Arbu	e of Disposition (Name of Propagation Com. 3	/22/08 Ba	Location - City or Town, Stete LETMORE, MD
Balt	permit. Pag Department Important: I eny injury o once.		21. Signature of an aral Serval Lic	censee	22. Name and Address of Facility 5126 Belair R		
1			23a. Part1. En by e disease, or co shock, or leart failure. List on	omplications that caused the death.	Do not enter the mode of dying, such as ca	ardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician	17. 1	Immediate Cause (Final disease or condition	estables.	me Deelme		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):		
ı,	LXG!!!!!!C!	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	reg Enbolon		
	nsi XX ad	nine	Cause (Diseese or injury	De 0 10	Ven thank	31-	
	be executed sicien and so	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):	: - ' - '	
68760,	cate be exphysicien the buria			Cher	the Heart	Forthe	
	ng ph as th	Medicai	IF EFMALE.	0			
О. Вох	The law requires that the death certificate be executed to has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	by Physician/A	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetel d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
<u>a</u>	igned by be detact	/ Ph	Part II. Other significant conditions	s contributing to death but not resulti	ing in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ds	n sign	Q p	Early	Donate	and Pychon	1 ☐ Yes	2 No 3 Probably 4 Hinknown
00	s been should	Completed	Chanal	in dal	) (	24a. Was an	24b. Were autopsy findings available
Re	The law cate has page 2	Eo	0 1) ***			autopsy performed	
ita	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical		26. Place o	of Death (Check only one)	
Ž V	hysich this cer al direct	Tof	examiner? 1 🗆 Yes 2 📑 No		P/Outpatient 3□ DOA Other: 4 Nurs	ing Home 5 Residence	e 6 Other (Specify)
Division of Vital Records,	After Uner		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigal	(Month, Day Year)	8b. Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how i	injury occurred
Divis	i or Attend after death Director: /	ertific	3 Suicide 6 Could no 4 Homicide determine	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, State)
	To the Hospitel or Att within 24 hours after of To the Funeref Direct completely filled in by	Medical Certification;			edge, death occurred at the time, date and n and/or investigation, in my opinion, death		
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	, Q	29c. License number	29d.	Date signed (Month, Day, Year)
	P S P O		) Sc	War	D3141	64	3/16/04
	7		30. Name and address of person with A 112 A	no completed cause of death (Item 2	(3a) (Type, Print) N. GVTAVO ST	Smt 308	BALTIMORE MY
	Sta	te	31 Date filed (Month, Day, Year)	32. Progistrar's Signatu	(0		2/20

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

MAR 1 8 2008

		•	For State Registrar	Ce	rtificate of	Death	F	Reg. No. 200	8 08695
9	Physicia	an	1. Decedent's Name (First, Middle, Last)	1			Date of Dea     Month	ath Day Yea	3. Time of Death
	/Medic		George G	Gordon			March	13,200	
	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death	1	4c. County of De	
			Union Memorial Hospital	land hinth days		timore I if Under 24 Hrs.	0 Date of Bird	N/	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. 217–18–6189 1 X 2 F 84	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day	/, Year)	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent				OCT 30,	1923 Ma	ryland
	land ow at			ty, Town or Lo	ocation				10d. Inside City Limits
	Many I-f sh fied	ţo	MD Howard		E1kı	ridge			1 □ Yes 2 No
	r 28s	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	th wit 23a o ist be	alD	6614 Highland Avenue			21075		US	A
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	. 14. Race - Ar Black, Wi	nencan Indian, nite. etc.
2	or it		1 □ Never Married 2 ▼ Married 1 ▼ Yes 2 □ No If Yes, Give WW 3 □ Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 ▼No	Specify:		Specify:	
Ś	ural"	d by			dent's Usual Occur	nation		16b. Kind of Busines	White
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7	withi ene. than he M	ᇤ	Elementary/Secondary (0-12) College (1-4or 5+)		Lawye	r		Federal	Government
3	filed Hyg other ent, t		17. Father's Name (First, Middle, Last)		паку с		ne (First, Middle,	Maiden Surname)	OOVEL HINCHE
O	lid be lental <b>ked</b> ic ev	To Be	George Bonaventure	Bowe	rs	Ca	rrie	Sonner	leiter
<u></u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "hatural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's Name/Relationship (Type. Print)					er, City or Town, State	, Zip Code)
₹	1 and 2 Health a em 27 is		Gwendolyn B. Bowers, wife		Highla		ue El	lkridge,	MD 21075
ב ב	of He		20a. Method of Disposition 20b.	Place of Dispercemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
	Pages 1 nent of H ant: If Iter ury or oth		1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	tro Cro	ematory,	Inc. 03/	14/08	Baltimo	re, MD
5	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee George MacNa		2. Name and Addre			Society o	of MD, Inc.
<u> </u>	<b>8 % % %</b>		Less E. Mar diff	17	299 Fre	derick R		altimore,	
			23a. Part1. Enter the disease, or complications that caused the deaf shock, or heart failure. List only one cause on each line.	th. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	mon	la				Onset and Death 5 Days
	/Medical		resulting in death)  Due to (or as a consec						
	Examiner	,	Sequentially list conditions.						
IIo	₽ _/#	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence ot):					
_	and and	хап	that initiated events resulting in death) Last	quence of):					
5	be e) ician buria			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
00	ing physician and as the burial-transit	Medical	d						
_	law requires that the death certificate be executed as been signed by the attending physician and as should be detached for use as the bunal-transit	-	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnant					23d. Date of	delivery
o o	atter for u	ciar	in the past 12 months?  1 ☐ Live birth 2 ☐ Fet.  1 ☐ Yes 2 ☐ No		□Ectopic pregnanc □ Other <i>(specify)</i> _	У		Month	Day Year
į	w requires that the death ce been signed by the attendir should be detached for use	Physician/	9☐Unknown 9☐Unknown				1		
, T	s that ned b	by PI	Part II. Other significant conditions contributing to death but not res	sulting in the (	underlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	e to the cause of death?
ž	quire en sig uld bi	a p					1 🗆 '	Yes 2□No 3□	Probably 4 Wunknown
ecords,	aw re	Completed					24a. Was	an 24b. Were	autopsy findings available to completion of cause of ?
C	The I	Eo					autoj perfo 1∐ Yes	rmed? death	i? 'es 2□No
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	nysic nis ce I direc	ToE		] ER/Outpatie	ent 3 DOA Oth	her: 4 ☐ Nursing I	Home 5□Resi	dence 6 □Other (S	pecify)
0	ng Pl		27. Manner of Death 28a. Date of Injury 1 ☑Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occurred	
SION	tendil eath. or: A	catic	2 Accident investigation			]Yes 2 □No			
<u> </u>	or At fter d Direct in by	Certification:	4 Homicide determined 28e. Place of injury - At houilding, etc. (Speci		treet, factory, office		28f. Location (		Rural Route Number,
ב	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2		200 Codifier	noudedae de-	th occurred at the	time data and nin-	o and due to the	course(s) and man-	r as stated
	Hos 24 ho Fun tely f	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my kn (Check only 0 ☐ Medical Examiner: On the basis of examiner and manner stated.						
	o the ithin ( o the omple	Mec	and mariner states.		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
ı	F ≯ F ŏ		1 Deline K Namel	1 A	1.D AT 2	4200	46	March	13, 2008
,	ONH		30. Name and address of person who completed cause of death (Ite Av I & C A A A A A A A A A A A A A A A A A A	em 23a) (Type	Print)	1001	18	1 .2 11	- ^ ^ / \\
	you.		Arleen K Lamba. W	nim	Memo	orial M	OSPITA	il, Balt	imore, MD.

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician MARCH HAZEL LUCILLE BAYER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7819 OAKDALE AVE BALTIMORE ROSEDALE If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs Director 219 10 9667 82 03/30/1925 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any Injury or other traumatic event, the Medical Examiner must be notified at BALTIMORE Director MD ROSEDALE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 7819 OAKDALE AVENUE 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Ifem 27 is marked other than "natural", or Ite 1 □Never Married 2 □ Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No WHITE ģ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **GEORGE** DEAN LENA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL L. BAYER JR. II/SON 155 STARWOOD LANE WIRTZ, VIRGINIA permit. Pages 1 ar Department of Hea Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL CEM 3/19/08 MIDDLE RIVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of) Physician/Medical þ Completed

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica completely

Be

Certification:

Medical

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknowh	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectop	ic pregnancy r (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	ng cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
				1 ☐ Yes	2 No 3 Probably 4 Monknown
				24a. Was an autopsy performed? 1  Yes 2	
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1X1Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, street, factify)	ctory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier (Check only one) Certifying PI	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occur ation and/or investiga	rred at the time, date and place ation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	70		29c. License number	29d. D	Date signed (Month, Day, Year)
1 Hattale 1	WD Doput	4	D18667	M	arch 18,2008
30. Name and address of person who	completed cause of death (Ite	23a) (Type, Print)			

5:00P M

1 ☐ Yes 2 X No

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6 32, Registrar's Signature eHill CTLAtherville, Md 21093

Division or Vital Records, P.O. Box 68760,

12+1

State Registrar 29b. Signature and title of certific

MI ella

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 18 2008

32. Registrar's Signature

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OSLER DRIVE TOWSON, MARYLAND 21204

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMIND ITEM/26 per PHYS C877, 3/18/08 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** March 14, 2008 11:32PM Helen Patricia Buckley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Joseph's Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 X F Yrs. Director 95 Nov 7, 1912 213-10-6382 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Maryland Baltimore Baldwin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5220 Sweet Air Road 21013 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. δ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laskowski Ignatius Abramczyk Amelia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Buckley/Daughter 5220 Sweet Air Road, Baldwin, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Bunal 2 □ Cremation 3 □ R 3 ☐ Removal from State 3/19/08 John Cemetery Hydes, Maryland Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementa **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ tact infection 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy performe 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home - 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mark Lamo MO 034521 3-17-8

DHMH 17 Rev 1/2001

State Registrar 9 Schilling Rd., Hunt Valley, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mark Lamos, M.D.

31. Date filed (Month, Day, Year) MAR 1 8 2008

		Please Type or F				-	_	
		1 - State Of State Of Registrar	Maryland / Depa Ce	artment of r rtificate of		ntai Hygie Reg.	0000	08699
Physici	an	Decedent's Name (First, Middle, Last)  Walter  C.	Baran			Date of Death Month March 15	Day Year	3. Time of Death
/Medio		4a. Facility Name (If not institution, give street and num		4b. City, Town, o	or Location of Death	arch 15	4c. County of Deat	12:15 A M
		9660 Magledt Road			kville		Baltin	nore
Funeral Director		5. Social Security Number 6. Sex 17 M 2 F	. Age (In yrs. last birthday) 88 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Young)	9. Birt 1919 Con	hplace (State or Foreign untry) necticut
w w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
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eath w	eral	7478 School Avenue  11. Marital Status 12. Was Deced	ent Ever in U.S. 13.	212: Was Decedent of I		fv Yes or No-	USA 14. Race - Ame	rican Indian.
after d or iten		Armed For 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give	es?	If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	can, etc.)	Black, White	
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and d be fill ental H ced oth c even	o Be	17. Father's Name ( <i>First, Middle, Last</i> )  Kandrat Baran			18. Mother's Name (		iden Surname)	
Taryland 212 2 should be filed within and Mental Hygiene. is marked other than sumatic event, the Mental Hygiene.	2	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street	and Number or Rural		City or Town, State, 2	Zip Code)
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IIIIMOre, IMaryland ZIZIS-UU3O nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notifiled at e.		20a. Method of Disposition   1	tate cemetery, cre	slaus Cen		. 19,  _	c. Location - City or altimore,	
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any per grand		Chithony Com	7	110 Solle	ers Point R	oad, Dur	ndalk,MD.	21222
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)  2 Medical Examiner: On the ba	sis of examination and/or i	nvestigation, in my	opinion, death occurred	d at the time, date	e and place, and du	e to the cause(s)
To the vithii To the comp	Me	29b. Signature and title of certifier	222	l 1	se number	29d	Date signed (Mont	th, Day, Year)
<b>^</b> D	1	30. Name and address of person who completed cause	of death (Item 23a) /Tune				3/17/2	
.70	5 5	LAWRENCE BOAS or	D, 54 S	COTT AD	Am Ro. C	OCKEYS	JILLE, MD	21030
Sta Registi		31. Date filed (Month, Day, Year) 32. Re	of death (Item 23a) (Type	S.				
DHMH 17 Rev 1/2		MAK 1 8 2000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:17 P M George Edmond Bridson 2008 March 11. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 13, 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral 1** M 2□ F Days 235-24-2557 Ohio 84 1923 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Examiner must be USA 621 Foxcroft Drive 21014 Funeral 14 Bace - American Indian Items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X es 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 🌠 No Specify: Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer U.S. Government 12 should be filed whand Mental Hygier is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Maurice Madge Emelyn Cain Bridson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once. 6211 Foxcroft Drive, Bel Air, Maryland, 21014
Disposition (Name of Date 20c. Location - City or Town, State <u>Margaret Bridson / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 3/17/2008 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sid Servicerhicenses 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** JEPTIC 24 hours /Medical Due to (or as a consequence of): PNEUMONIA Examiner 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) ttending physician or use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No the 9□Unknown 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMONTA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director; filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

0×

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ason Birnbau

MAR 18

2008

M.D. 500 Upper Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeak

29c. License number

00056296

29d. Date signed (Month, Day, Year)

11-2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Gertrude E. Bankhead 2008 longh 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis Loch Raven Parkville Balto If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 🔊 🗖 F 220-20-4582 Director 84 10-10-1923 VA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ner must be notified at 1 ☐ Yes 2 ☐ No Director MD N/A Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with o 18 Warren Park Drive 21208 U SA items 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 🏖 No Black Specify: 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) r than the Me Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 12th grade N/A Waitress Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clem Jones Bessie Neal ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 Chattahoochee Run Dr Suwanee, item 27 l Robyn Davis -Granddaughter 30024 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3-15-2008 Baltimore, MD Baltimore Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 21202 1101 E. North Avenue Balto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as 38 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No s certificate has t irector, page 2 s autopsy perform 1☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. I Director: A od in by the fu 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

Division or Vital Records, within 24 hours aft

To the Funeral Di

completely filled ir

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. Liçense number 29d. Date signed (Month, Day, Year)

100 h 31. Date filed (Month, Day, Year)

32 egistrar's Signature

ddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

State of Maryland / Department of Health and Mental Hygiene amend #5&10e Per FH G877 3(26) #08 at tho Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician E. Bush Mildred 5:28 p^M 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. Joseph Richey N/A 8. Date of Birth (Month, Day, Year) 8-26-1954 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2 X Director MD 53 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mertal Hygiene. Instit if Item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notifited at my or other traumatic event, the Medical Examiner must be notifited at 1 X Yes 2 □ No Baltimore Funeral Director MD N/A 205 Street and Number 10f Zip Code 10g. Citizen of What Country? USA 21223 203 Street N. Amity 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Black þ 3 ☐ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) N/AElementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 10th grade 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucille Harris Jimmie Jenkins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Farmer - Daughter 205 N. Amity Street Balto, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: if Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-18-08 Greenmount Cem Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East lad was 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician uns year) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s has autopsy perform this certificate 1∐ Yes Division or Vital 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) \$ 10501 CQ 5 Residence 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onits 31. Date filed (Month, Day, legistrar's Signature State 2008 Registrar 8

3/14/08

DIED

BUSH

MILDRED E.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Pay 3, 2008 MARCH **Physician** 6:38P BLUMBERG ALBERT /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Towson Center Saint Joseph Medical | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O9/04/1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 X M 2 □ F MD 217-07-8037 90 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No PIKESVILLE Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 11 SLADE AVENUE, #315 Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) DRUG STORE OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FREEDMAN BLUMBERG HANNAH ို EDEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health an ant; if item 27 is ury or other traus 11086 HIDDEN TRAIL DRIVE, OWINGS MILLS, MD 21117 FRAN FIDLER / DAUGHTER 20b. Place of Disposition (Name of ARMONO CONG. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If 4 ☐ Donation 5 ☐ Other (Specify) 03/16/2008 BALTIMORE, MD 21. Signature of Juneral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown p signed b I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe es 2 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death. 1 Natural 5 ☐ Pending investigation within 24 hours arrer uses...

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 ☐ Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D15452 0 tame and ad ress of person who completed cause of death (Item 23a) (Type, Print) 21204 MARYLAND M.D 7601 OSLER DRIVE TOWSON. 31. Date filed (Month, Day, Year) BESSENT 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of W	arylanc	'	ificate of	Death	, ,	eg. No.	0 0070
No.	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of Dear		3. Time of Death
1	/Medic	al		lessing		-	4h City Town o	L continue of Dooth		16 C	S D AM
	Examin	er	4a. Facility Name (If not institution, gi		w			r Location of Death			Sharp
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
6	Director		210-24-40/2	1□M 2 <del>X</del> □F	83	Yrs.	Months Days	Hours Min.	1/9/19	25 M	MARYLAND
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation				10d. Inside City Limits
	Maryl -f sho	tor	MD BALTIMO	RE	PA	RKVILL	E				1 □ Yes 2 🛣 No
	th the or 28a e noti	irec	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	t Country?
	23a cust b	ral	1713 WHITE OAK A	VENUE			21234			USA	
	er des Items ner m	nue	11. Marital Status	12. Was Decedent Armed Forces?		i. 13. W	as Decedent of H Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
36	ours after death with the Marylar rai", or Items 23a or 28a-f show Examiner must be notifiled at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	NO	1	□Yes 21XINo	Specify:		Specify:	WHITE
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	15. Decedent's E (Specify only highest gi	Education		16a. Decede	ent's Usual Occup	pation	kina	16b. Kind of Busin	ess/Industry
21	within 7 ene. than "u	nple	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of worl d)	ang .		_
	iled w Hygiei ther ti	S	12TH GRADE  17. Father's Name (First, Middle, Las	t)		OWNE	R	18 Mother's Nam	ne (First Middle i	RESTAURA Maiden Surname)	ANT
anc	d be f ental h ced of	o Be	ANDREW BECHELLI	4					CUNAVI	maraerr Garriarne,	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	P	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing	Address (Street			r, City or Town, Sta	nte, Zip Code)
	and 2		WILLIAM E. BLESS	ING, JR./S	ON	259	MAGOTHY	BRIDGE RI	D. PASA	DENA, MD	21122
Baltimore,	of He of He of oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State	20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other pla	ce)	Date	20c. Location - City	y or Town, State
<u>H</u>	trnent of trant: If it tant: If it		4 □ Donation 5 □ Other (Spec	ify)	NEW	_CATHE	DRAL_CEM	1. 3/19	9/2008	BALTIMOF	RE, MD
Bal	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Lice	ensee							HOME, P.A.
			23a. Part1. Enter the disease, or cor shock, or heart failure. List onl	nplications that caused	the death.			I RAVEN BI			21286 Approximate
	Physician [*]		Immediate Cause (Final		- ~			3,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. <u>کعب</u> Due to (or as		ence of):	· ·		_		years
	Examiner		Sequentially list conditions	b. ————							
	Da r Jis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to (or as	a conseque	ence of):					
	and %	хаг	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):					
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and a sage 2 should be detached for use as the bunat-transit	edical Examiner		<b>√</b> d							
	rtificat ng phy as th		IE EEMALE.								
Box	ath ce ttendir or use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3 🗆	Ectopic pregnanc	y		23d. Date o	,
	that the death cer ed by the attendin detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	ath 5□	Other (specify) _				24,
, P.O	that the by detact	/ Ph	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the und	derlying cause gi	ven in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
rds	quires en sign uld be	q pa	Jegues						1 □ Y	es 2□ No 3[	Probably 4 Unknown
Records,	ystelan: The law requires the list certificate has been signed director, page 2 should be de	Completed by	CAD						24a. Was a	an 24b. We	re autopsy findings available or to completion of cause of
Æ.		MO.							perfor	med? dea	ith?  Yes 2 \Begin{align*} No
Vita	Physician: this certificaral director, I	Be	25. Was case referred to medical examiner?	Hospital:			l ou		th (Check only or	пе)	
o	Phys r this ral dir	٦.	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpation		R/Outpatient 28b. Time of	3 DOA			ence 6 Other ow injury occurred	(Specify)
on	th. :: Afte	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	28c. Inju Wo M 1	rk? ]Yes 2 □ No	200. 200020 11	on injury socialisa	
Division or Vital	Atter er dea ector by the	Certification:	3 Suicide 6 Could not l 4 Homicide determined	Zoe. Place of III	ury - At hon c. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S Cify or Tow	itreet and Number	or Rural Route Number,
Ö	ital or its afte ral Dia led in							6			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 ☐ CertifyIng P (Check only 2 ☐ Medical Exa	hysician: To the best miner: On the basis of and manner st	f examinati	rledge, death on and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occu	e, and due to the our arred at the time, o	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
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	J		31. Date filed (Month, Day, Year)	6 701 × C	Laco	S. A.	20,00	4202 7.	wsn 2	and 21:	207
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Russell J. Black 2:44 A M 14, 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Center Timonium If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ F Director April 26,1925 Pennsylvania 220-12-7878 82 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Maryland Directo Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 Funeral 7810 Harold Road 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3√ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DC NOT use retired) Back River-Patapsco Elementary/Secondary (0-12) College (1-4or 5+) Railroad Neck Railroad is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yolanda Mauro Bartlomae A. Montagna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard R. Black (Son) 1952 Youngston Road Jarrettsville, MD 21084 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition □Cremation 3□Removal from State
Company Entomomy permit. Pages Department of I Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation Meddowridge Mem. Park 3/18/2008 Dorsey, Maryland 4 Dopation peral Service 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1. Immediate Cause (Final Atheroscieruhic Cardiovascular Dispose **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) HUSNIC 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TARIO MAUMUUD 19, KINYO RUNU WESTMINISTER MD 21157 19, Ridyo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 8 2008 Registrar

08-	U١	960	

Mark Frederick Backley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 08706

		For State	lo. 3. Time of Death									
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	5	. Social Security Number 6. S	ex 7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth (N	MM/DD/YYYY)	Birthplace (State or Foreign			
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be fill hall H	Be	Edward J.	Backley	40h Mailin	a Address /Street	Gayle	Rural Route Numb	er, City or Tow	SMUND m, State, Zip Code)			
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Page ment tant:	М	4 Donation 5 Other Spec	y.	ro tre	matory Ir	of Facility C+	13/001	Dai <u>tii</u> Funeral	Home PA			
Baltimore, MID 21215-0U36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once	- 1	Donation 5   Other Specify:   22. Name and Address of Facility Stallings Funeral H   3111   Mountain Rd. Pasadena, Md. 21										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 1:25 P. M Milton Thomas Banks March 7 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept. 01 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Hours Min. 1 M 2 □ F 75 216-28-3893 Sept. Director Usual Residence of Decedent 10c. City, Town or Location 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any flury or other traumatic event, the Medical Examiner must be 1 and 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 10 the 1 2141 Beach Drive 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Ves 2 No Yes, Give 1 ☐ Never Married 2 ☑ Married Momas Banks Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Safety Supervisor Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lester Banks Elsie 0tt ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2141 Beach Drive Linda M. Baker asadena. (spouse Pasadena. MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 14 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signatur of uneral Se 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease shock, or heart failure. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonit /Medicai phlownay disease **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last us to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1X Yes 2 🗌 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🗌 No 1 ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:..

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospitai 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe ZDOX M Name and address of person who completed cause of death (Item 23a) (Type, Print) Deve 31. Date filed (Month, Day, Year) .301 Hospi Burne mo. 21061. gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 18

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 6:00 PM March 14, 2008 Α._ Broderick, Sr. /Medical Marvin 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Parkville Baltimore Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 XM 2 ☐ F July, 20,1919 Maryland Director 216-01-0510 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Parkville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8820 Walther Blvd. Apt. 4514 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coast Guard 8th. Grade Sheet Metal Mechanic d 2 should be filed with and Mental Hygier 7 Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Starkey Alice George Broderick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important; if Item 27 is any injury or other trans 21234 8820 Walther Blvd. Apt. 4514 Baltimore MDDoris Broderick/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/18/2008 Baltimore MD Moreland Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc. 21206 6415 Belair Road Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence f): Dementic disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 within 24 hours a 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760, Manny Bridenck To the Hospital

.00pm

1-2008

State Registrar manics

Anna

29b. Signature and title of certifier

30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

1)58646

Boslevard

29d. Date signed (Month, Day, Year)

March 14, 2008

Parkvilla, UNO 21234

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

State Registrar 29b. Signature and itle of certifier

Kakesh Arora Mb. 31. Date filed (Month, Day, Year) MAR 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

14300 Gallant Fox Lane suite 222 Bourse, MD 20715

D20108

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 100 per the 877 3-18-08 yt Beattinent of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Rthwest Hospital andallstown 41 MORE 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**Ø**M 2□F HEMORE ML Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore 1 ☐ Yes 2 KNo Funeral Director Baltimore OWSON 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21 Drook 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Programmer 12 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname ၉ 19a. Informant's Name/Relationship (Type. Plint 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00050n 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation Forest Hill MU 14/08 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on useful ine. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ducito (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 1 ☐ Yes 2∏ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 4 No 25. Was case referred to examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manne 10 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Derritfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ÖRIGINAL

DHMH 17 Rev 1/2001

State Registrar

FRANCIS KHOO, MD

MAR 18 2008

31. Date filed (Month, Day, Year)

Specker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS KHOO, MD 200 MEMORIAL AVE, WESTMINSTER, MD 2115

32. Registrar's Signature

3-17-08

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vati	naniei E Car		State of Maryland / Dep 1- For State Co Registrar	ertificate of		iygiene _{Reg.}	No. 200	8 0871			
	Physicia	an/	Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death			
Мe	dical Exami	ner	Nathaniel E. Carter			Month E February 29		0827 hrs			
E) A			Facility Name (If not institution, give street and number)     Mercy Hospital	4	lb. City, Town, or Location of Dear Baltimore	h	4c. County of Dear	n			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year   If Under 24Hi		MM/DD/YYYY) 9. B				
	Director		214-50-5045 1XM 2 F	58 Yrs.	Months Days Hours Mi	n. 8/9/1949	unk Fore	gn unk			
	any	ed by Funeral Director	Usual Residence of Decedent  10a. State unk 10b. County unk 10c. Ci	ity, Town or Location	on		·unk	10d Inside City Limits			
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	h the I 3a or		5949 St. Regis Road		21206		US.				
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	Baltimore, permit. Pages I ar Department of He Important: If ite	ı	21. Sign were of Funeral Dervice Licensee 1d S./ Warde Directo	22. N	rest_vet3/2 lame and Address of Facility Mar	ch Fl-East;	1101 E Nor	th ave.			
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	Box 6876 e death certificate the attending phy led for use as the b	iciai	past 12 months?  4 Pregnant at time of	- =	her (Specify)			,			
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1			30. Name and address of person who completed cause of death (I'	tem 23a)							
			Margarita Korell MD. Assistant Medical Exan	·	enn Street, Baltimore, Mi	O 21201					
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				1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	h Day Year		3. Time of [			
		Physicia Medic/		Hazel V. Cromu	ell						March	13	2008	9:28	Рм		
		Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or		of Death			ounty of Death				
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		Funeral		5. Social Security Number 212-74-8240	6. Sex 1 ☐ M 2 □ F	7. Age (In yrs. 101	Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birth (Month, Day, 10-31-1	Year)		place (State or ntry)	roreign		
		Director		Usual Residence of Decedent							10-31-1	700		/land			
		yland 10w		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	-					10d. Inside City			
		s 1 and 2 should be filed within 72 hours after death with the Maryland if Health, and Mental Hygiene Item 27 is marked other then "netural", or items 23e or 28e-f show other treumatic event, the Medical Examiract must be inclined at	tor	MD Balt	imore		Towson							1 🗌 Yes	2 🔀 No		
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		deatl	ner	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto			ecity Yes or No- Rican, etc.)	14	14. Race - American Indian, Black, White, etc.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ALICE BELLE CORNES MARCH 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonuim Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Director 220-01-2715 91 June 9. 1916 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 Landmark Drive, Unit M Completed by Funeral 21050 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ➡ Divorced Year or Dates: White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Brooke Fisher မ Theodore Lacey Silling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Bell / Daughter 1700 Landmark Drive, Unit M. Forest Hill, MD 21050 20c. Location - City or Town, State Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1⊠ Burial 2 □ Cremation 3 ☐ Reprioval rom State ion 5 🗍 her (Specify) Bel Air Memorial Grdn 3-15-08 Bel Air, Maryland e of Fune 21. Signa McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. rart1. Enter the lise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) tavanced years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physician and as the burial-transit Due to (or as a consequence of): death certificate be Completed by Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 2 ☐ Fetal dea 4☐Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month 5 ☐ Other (specify) n signed by the a 25 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has le 2 autopsy performed? page this certificate 250 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200 No 1 Inpatient dir ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

2008 P.O. Records, or Vital CORNES Division To the Hospital

> 4 State

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD

29c. License number

29d. Date signed (Month, Day, Year) 2008

(X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

2008

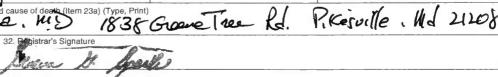
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle, Last. 2. Date of Death **Physician** DL BUS 2000 /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and I Examiner PAINTED If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) 06/11/1936 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last hirthday) **Funeral** Days Min Months Hours 1 □ M 2 X F 71 Director 215-32-5355 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. a or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Director BALTIMORE PIKESVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 802 PAINTED POST COURT 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married WHITE "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced or than "natura the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SYSTEMS ANALYST SOCIAL SECURITY permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, til 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **LITOFSKY GLAZER** ROSE JOSEPH ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 PAINTED POST COURT, PIKESVILLE, MD 21208 HARRY COLBUS / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State HEBREW YOUNG MENS 03/17/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final rocen oute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a d be detached for 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death.

I Director: After to in by the funera Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Pay 31. Date filed (Month, Day, Year)

2008



address of person who completed cause of death (Item 23a) (Type, Print)

. Karpa, My

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month March 200 12 James Albert Curtis 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yis. last birthday) 5. Social Security Number Months Days Hours 1**1**2 M 2 □ F 47 216-56-4602 Maryland 12-5-1960 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 ☐ Yes 2 M No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 825 Cedar Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: American Indian 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vera P. Chavis <u> James A. Curtis</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Banyan Wood Court #202 Essex MD 21221 Wilma J. Petti 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 20 Cremation 3 ☐ Removal from State Hilltop Service Corp. 3-18-2008 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundal 21. Signature of Funeral Service Licensee Avenue. Dundalk MD 21222 Wise 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0 Due to (or as a consequence of): 5 cumularly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check onl one 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 25 No Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

**Examiner** law requires that the death certificate be executed and physician attending p P.0. signed by Division or Vital Records, certificate has been si rector, page 2 should Hospital or Attending Physician; The this After t n 24 hours after death.

In Funeral Director: Af olderly filled in by the fun

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification:

Medical

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and tipe of certifie

31. Date filed (Month, Day,

30. Name and address of person who

MAR

Year)

8

2008

**Funeral** 

Director

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, <u>the Medical Examiner must be notified at</u>

2 should be filed within 72 hours after n and Mental Hygiene. Is marked other than "natural", or Iter

Pages 1 and 2 sl ment of Health an ant: If Item 27 is r

**Physician** /Medical

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32. Flegistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Mary	-	artment of F		Mental Hy	giene Reg. Na	08	08717
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	th with the A 23a or 28a- ust by notifi	Funeral Director	10e. Street and Number 3530 Resource		indallst . 118	10f. Zip Code 21133			10g. Citizen of	What Count	
5-0036	ours after dea ral", or items		11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1		Was Decedent of H if Yes, specify Cuba 1 □Yes 2 ☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Spec	ace - America ack, White, et ify: Bla	etc.
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Maryland	nould be fill d Mental H narked ott natic even	To Be	17. Father's Name (First, Middle, Last) Sydney Dyer				18. Mother's Nam	Haught	on		
	t. Pages 1 and 2 s rtment of Health a rtant: If Item 27 Is njury or other trau		19a. Informant's Name/Relationship (7 Jacqueline Dye:		3530	Resource sition (Name of natory or other place	Dr Apt.			wn, MD	21133
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	) Nemova: from State	Metro Cre	matory, I	nc = 3/14	<b>/</b> 08	Baltimo	ore, M	D
Ba	permi Depa Impo any ir		23a. Part 1. Enter the disease, or comp	lications that caused the	129	Name and Addre emation Freder: er the mode of dyir	<del>вск ка в</del> а	<del>ltimore</del>	• MD 23	7.78	Approximate Interval Between
	Physician /Medical Examiner	<u>.</u>	shock, or heart failure. List only of disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. CARDIOMYOF  Due to (or as a cor	nsequence of):						Onset and Death
8760,	cate be executed physician and the burial-transit	ical Examiner	r any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cord							
O. Box 6	ath certific attending p for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant et time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	y			ate of deliver	ory Day Year
rds, P.	w requires that the de been signed by the s should be detached for	ğ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.				e cause of death? ably 4 💢 Unknown
of Vital Records,	in: The law re ificate has be or, page 2 sho	Completed	25. Was case referred to medical					1 □ Yes	psy ormed? 2 X No	prior to con death?	osy findings available npletion of cause of 2  No
Division of Vit	Attending Physician: The I or death. ector: After this certificate his by the funeral director, page	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  investigation	28a. Date of Injury (Month, Day, Yea	2 ER/Outpatier 28b. Time of Injury	28c. Injur Work	4 Li Nursing H	ome 5 Resi			) HOSPICE
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fr			28e. Place of Injury - building, etc. (Si	pecify)		ne, date and place	City or To	wn, State)		I Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only one) 2 Medical Example 29b. Signature and title of certifier	Iner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my o		rred at the time,	date and place		
	0		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	13725		3/1:	3108	7
	Sta Reģistr		DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year) MAR 1 8	2300 DULA 32. Redistrar's S		EY RD.	rimonium,	MD 210	93		

DHMH 17 Rev 1/2001

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MARCH 13, 2008

CECIL DYER

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician GARL 30208 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 31273 SECOURS HOJ PITAL BALTIMORE mg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | FEB 16, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Maryland 53 Director 213-62-5494 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 28a-f show 1 ☐ Yes 2 XNo ns 23a or 28a-f sh must be notified **Funeral Director** Baltimore Baltimore MD 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21229 4600 College Avenue USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give ★ Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No 5 Specify þ White 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Factory Worker Paper Office Supply 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sr. William J. Drury, Betty Ba11 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 4600 College Avenue Baltimore, 21229 William J. Drury, Jr., brother MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 03/12/08 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Espirato-/Medical Due to (or as a on sequence of): Examiner nvonic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Obstructive Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ elize a se 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ HO autopsy performe 2 12 No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To 27. Mann of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A

Baltimore, Maryland 21215-0036

State

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DHMH 17 Rev 1/2001

Medical

29a Certifier

29b. Signature and title of certifier

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and manner stated

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32. Pagistrar's Signature,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

00061439

29d. Date signed (Month, Day, Year)

2600 LIBBLY HELLITS NEWLE, BALTIMORE, MY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 2008 MARE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Be (0) erside Cami If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/20/1916 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 92 Months 1 M 2 K MARYLAND 218 01 5649 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2X No HARFORD STREET Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3432 CONOWINGO ROAD 21154 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEON SOBUS ANGELA BOCHWIAK ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STREET, MD 21154 RAYMOND B. DROZD SON 3432 CONOWINGO RD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD STANISLAUS 3/18/08 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Social Licens of 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) oconfolio /Medical Due to (or 's a consequence of): Examiner Due to for as a conforuence Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be del þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Inpatient Medical Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 m 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State	State of Ma	ryland		artment of I r <i>tificate of</i>				2111	18	08720
			Registrar  1. Decedent's Name (First, Middle, Lat	st)		061	incate of	Deali		Date of Dea	ath		3. Time of Death
	Physici		ALLEN	DAVIS					~	Month 1arch		Year	6:30 A.M
	/Medic		4a. Facility Name (If not institution, give				4b. City, Town, or Location of Death				4c. County of		
		Я	Howard County Ge				Colu				How	ard	
H	Funeral		5. Social Security Number 6. S		ast birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	Date of Birtl (Month, Day	v, Year)	Cour		
	Director		377-46-9597 Usual Residence of Decedent		60	110.				June 2	20,1947	Mic	higan
	yland now at		10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	e Mar Sa-f sl	ctor	Maryland Baltime	ore	Cc	ckeys	ville_						1 ☐ Yes 2X No
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	s 23a	eral	10514 Pot Spring	Road 12. Was Decedent E	vor in II 9	2 112 1		030	rigin? (Specif	Vac or No.		SA	an Indian,
	fter de	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 🕅 N			Was Decedent of I If Yes, specify Cub		an, Puerto Rio	can, etc.)	Black	, White,	
21215-0036	be filed within 72 hours after death with the Maryland nal Hygiene. cd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitled at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1⊡Yes 2∭XNo	Specify	<b>:</b> :		Specify:	Whi	lte
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	1 and 2 Health a		Karen Patricia Da	avis/Wife	,		514 Pot :	Sprin	g Road	, Cock			
ore	S to to		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pl	lace of Dispo emetery, crei	sition (Name of natory or other pla	ice)	3/17/	08	20c. Location -	City or To	own, State
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0	he dea the a	ysic	1 Yes 2 No	4□Pregnant at t 9□Unknown	time of de	eath 5□	Other (specify) _						24,
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director, it is a second to the funeral director.	Medical	29b. Signature and title of certifier	and manner stat	ted.		29c. Licen				29d. Date signed		
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	15		Shaun Evons	Howard C	ytrue	Gener	al Hospit	al 57	155 Cod	lar Lane	(olumbia)	Mary	and 21044
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month  $14^{4y}_{,}2008$ **Physician** 1:24A M D'Onofrio March Frances /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Owings Mill 316 Tollgate Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 4, 1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🛛 F 86 Maryland 220-01-4989 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 □Yes 2 No Maryland Baltimore Owings Mill Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 USA 316 Tollgate Road by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Tailoring 8 years permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Rusin Joseph Maciolek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 316 Tollgate Road, Owings Mill, Maryland Nancy King 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 18, 1 XBurial 2 □ Cremation 3 □ Removal from State Druid Ridge Cemetery Pikesville, Maryland 2008 4 □ Donation 5 □ Other (Specify) 21. Signalure of Furteral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Part1. Enter the disease, on complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** , year /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq Examiner certificate be executed burial-transi attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the IF FÉMALÉ: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a detached f □Yes 2□No 9 Unknown signed by the period of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy pertormed this certificate 2□No 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 2 ER/Outpatient 1 Inpatient 3□ DOA 5 Residence 6 ☐Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred After 1 the Hospitai or Attending 5 Pending investigation within 24 hours after con-1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certif n who completed cause of death (Item 23a) (Type, Print) 30. Mame and address of pers 1701 ahl

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 8 2008

Registrar's Signature

ame	es Davis		State of Maryland / Department of Certificate of Registrar		giene Reg.	No. 2006	0872
	Physicia	ın/	1. Decedent's Name (First, Middle,Last)	[	2. Date of Death Month D	av Year	of Death
Vied ⊶∢	ical Exami		James Davis	4b. City, Town, or Location of Death	March 15, 20	103 4c. County of Death	31115
			4a. Facility Name (if not institution, give street and number)  16 Wyndmoor Place #D	Gwynn Oak		Baltimore County	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth(	MM/DD/YYYY) 9. Birthplace (	State or
	Director		259-44-5292 1X M 2 F 74 Yrs	Months Days Hours Min.	01/13/	934   Foreign   Country) C	eorgia
	<b>,</b>	-	Usual Residence of Decedent			10d In	side City Limits
	ow any		10a. State 10b. County 10c. City, Town or Locat MD Baltimore Gw	ynn Oak			Yes 2 X No
	Aaryland 28a-f show i at once.	흱	10e. Street and Number	10f. Zip Code	10a.	Citizen of What Country?	
	he Mau or 28 ified a	Director	16 Wyndmoore Place, Apt. D	21207		United States	,
	0036 within 72 hours after death with the Maryland jene. rer than "natural", or items 23a or 28a-f sho Medical Examiner, must be notified at once.		11. Mantal Status 12. Was Decedent Ever in U.S. 13. Wa	I is Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto F		14. Race - American Indi White, etc.	an, Black,
	death or ite	Funeral	1X Yes 2 No	_	tiouri, cto./		
0	s after rral", niner	à	or Dates: KOTEAN FITA	Yes 2 X No specify:  "It's Usual Occupation (Give kind of w	ork done	Specify: Black 6b. Kind of Business/Industry	
2	2 hour	ted		ost of working life. DO NOT use retir		United States	3
\	5-0036 led within 72 hours at tygiene. other than "natural	Completed		l Carrier		Postal Service	æ
	P B 등 4	Be Cor	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	iden Surname)	-
	21215-Culd be filed volumental Hygimarked other cevent, the	Lson	4-1				
	D 2 should and M 7 is m	유	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	g Address (Street and Number or R			de)
	e, MD I and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Dispos	Buckhaven Way, Austrian (Name of cemetery,		20c. Location - City or Town,	State
	<b>&gt;</b> ≈ ≈ = ₹		1 X Burial 2 Cremation 3 Removal from State crematory or of Strong M		22/2008	Moultrie, Geo	rgia
	Baltimo permit. Page Department Important: injury or ot	-	4 Donation 5 Other Specify:	Name and Address of Facility Li			
	Ba Per Britis		W 1113 20	First Street Nor	theast,	Moultrie, GA	31768
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	he mode of dying, such as cardiac or	r respiratory arres	t, shock, or heart Appr Betv	oximate Interval ween Onset and
	Medical xaminer		Immediate Cause (Final disease a. End Strue Renal Disease a	nd Cirrhosis of Liver			Death
			or condition resulting in death)  Due to (or as a consequence of):				
		횰	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	7	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
	O, e be executed ysician and burial - transit	Ě	d				
	O, be executed sician and burial - transi	edical	☐ AMENDED 23a,27 per ME g87	8 4/16/08 amh			
	760 ficate by g physical the bu	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	etal death 3 Ectopic pregna	IDO.	23d. Date of delivery  Month Day	Year
	Sox 6876( leath certificate e attending phys for use as the b	sician/M	past 12 months?	etal death 3Ectopic pregna hther (Specify)	ПСУ	Wionat Bay	1001
	Box 6876 e death certificate the attending phy ed for use as the the	Physi	1 Yes 2 No 9 Unknown g Unknown				
	.O. that the ed by detach	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cau  2  No 3 Probably	
	S, Fluires 1 uires 1 n sign 1d be	edt			24a. Was ar	A De VACE 100	
	ord aw rec as bee 2 shou	plet			autops:	y prior to complet	
	Rec The I icate I page	Completed			1 <b>✓</b> Yes 2		2 No
	Vital Records, P.O. ysician: The law requires that the his certificate has been signed by director, page 2 should be detach	Be	25. Was case referred to medical examiner?  Hospital:   Inpatient 2 ER/Outpatient	26.Place of Death (Check		Residence 6 V Other: Scen	
	1 of V ding Phys After thi funeral di	Certification: To	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of	0 2011		ow injury occurred	-
	on C arth. rr: Af						
	Division of Vital Records, P.O. Box 68761 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Function After this certificate has been signed by the attending phy completely filled in by the functal director, page 2 should be detached for use as the t	reet and Number or Rural Ro	ute Number, City				
	Di To the Hospital within 24 hours a To the Funeral I completely filled	<u> </u>					
	e(s) and manner as stated. nd place, and due to the caus	e(s)					
	To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Da	
		_	laure m. Vivel	O.C.M.E.		March 16, 2008	
1			30. Name and address of person who completed cause of death (Item 23a)				
				Penn Street, Baltimore, MD	21201		
	S Regis	tate strar		N)			
DI	HMH 17 Rev 1/		ORIGIN	AL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DOLORES FREITAG 17,2008 MARCH 4:05A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS TIMONIUM BALTIMORE 8. Date of Birth (Month, Day, Year) 5 - 1 - 1 9 2 6 Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthdav) **Funeral** 1 □ M 2√2 F Months Days Hours 81 216-20-8269 Director Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City. Town or Location show 10a State or items 23a or 28a-f show BALTIMORE PARKVILLE MD 1 □Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7710 BAGLEY AVENUE 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify: WHITE Specify. 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION C & P TELEPHONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KOTESOVEC LOUIS J. MARY (KLIMA) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heaith an Important: If Item 27 is n eny Injury or other traun ANN DEINLEIN/NIECE 13 BELLMAN COURT KINGSVILLE, MD Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery: crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HOLY REDEEMER CEM 3-19-2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Day Year 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐Yes 2 🛣 No Division of Vital 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/08

State Registrar RD.

TIMONIUM, MD 21093

2300 DULANEY VALLEY

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIO MAHMOOD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 14, 2008 Year 8:40 P. Physician Carol Ann Freeland /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford County Upper ChesapeakeMedical Center Rel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🔀 F 63 215-44-1184 Oct. 5, 1944 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Bel Air Maryland HarfordCounty Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States death with 21015 413 Prindle Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: Race - Americen Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner once. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2XNo Specify: 5 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) N/A Home Paramount Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Audrey Marie Plantholt Robert Adam Meninimer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1310 West Jamettsville Road, Forest Hill, Maryland 21050 19a. Informant's Name/Relationship (Type. Print) Mr. Matt Freeland (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MaCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel March 17,2008 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air Jean of Lot 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day **Physician** /Medical Due to (or as a consequence of): **Examiner** Esquentially flet our difference if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 menths? 1 ☐ Yes 2 K No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes eeland ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death. within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 30. Name end address of pers

31. Date filed (Month, Day, Year)

8

Ann M000047009

pper Chesafeake Drive, Bel Air

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death
4. 25 PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month C/C Physician a AUDREY JANET FUNK /Medical Ac. County of Death 4a Facility Name (If not institution) give street and number 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 14, 1 Birthplace (State or Foreign Country) **Funeral** 1 M 2 M F 218-14-8033 Maryland 83 1924 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IM dical Examiner must be notified at 1 ☐ Yes 2 No Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21060 U.S.A. 30 Chester Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: U.S.A. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Emory Bo11 Katherine Jeanette Heagerich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 30 Chester Circle Glen Burnie, MD 21060 Za Za Karenna Suzian daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 Removal from State Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 2008 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue, Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician Physician/Medical as the l IF FEMALE for use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an certificate has autopsy 2 💢 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Ninpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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Baltimore, Maryland 2/215-0036

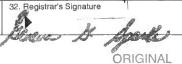
P.O. Box 68760,

Division or Vital Records,

State Registrar

MAR 1 8 2008

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician arch MAE 2000 /Medical County of Deeth City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 10 Medica TIMONA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-24-1969 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **X** M 2□ F Days 214-02-4186 39 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1¶Yes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2828 N. Calvert Street 21218 S A Funeral Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( John D. Featherstone Vivian Battle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2828 N. Angela Featherstone-Wife Calvert Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 3-17-2008 Balto, MD Greenmount Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 21202 MD1101 E. North Avenue Balto, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MOUNDIN Due to (dr as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 🗆 Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician for use as the buria To the Hospital or Attending Physician: ours after death.

eral Director: After this certification is by the funeral director, Medical Certification:

**Physician** /Medical

**Examiner** 

**Funeral** 

Director

Department of Health and Mental Hygiene, inatural, or Items 23a or 28a-f show important: If item 27 is marked other than "natural," or Items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore,

5 ☐ Pending investigation 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day, Year)

(Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b/Signature and title of certifier

6 ☐ Could not be

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes 2 ☐ No

re an address of person who completed cause of death (Item 23a) (Type, Print) 30 BONACUM MA

PL BULT TMORE, MO LINDS

State Registrar

gistrar's Signature

within 24 hours a To the Funeral I

08-02032
Leon Gogolski

on Gogolski	State of Maryland / Department of Certificate of	F Health and Mental Hygiene  F Death  Reg. No. 2008	1872
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death Year	
ledical Examiner		March 12, 2008 1747 nr  4b. City, Town, or Location of Death 4c. County of Death	
	Aa. Facility Name (if not institution, give street and number)     St. Agnes Hospital	Baltimore N/A	
Euporal	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State Country)	or Foreign
Funeral Director	200-26-639 1×M 2 F 73 Yrs	Months   Days   Hours   Min.	anla
	Usual Residence of Decedent	Los Inside	
any	10a. State 10b. County 10c. City, Town or Locat	100. Inside	
nd strow	Maryland N/A Ba	ltimore	
the Maryland a or 28a-f show iffied at once. Director	10e. Street and Number	10g. Citizen of What Country?	
ith the Maryla 23a or 28a-f.i notified at on		21229 USA 2 Decedent of Hispanic Origin? (Specify Yes or No. 14, Race - American Indian, E	Black
r death with or items 23 must be no	11. Marital Status 1 Never Married 2 Married 2 Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 13. Was If Y	as Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, E White, etc.	Jiddi,
or it.	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify: Specify: White	
rs after mine	or Dates:	nt's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
0036 within 72 hour giene. her than "natu Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life. DO NOT use retired)	
thin 7 thin 7 reference	unknown	unknown unknown	
5-0036 led within 7 Hygiene. Lother than the Medica	17. Fauler's Ivaine (1 list, wilddie, Edst)	18.Mother's Name (First, Middle, Malden Surname)	
21215-0036 Juld be filed within 77 Mental Hygiene. marked other than ic event, the Medical	OTTATOWAL	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of fleath and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f site or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	2 Carriage Court Baltimore, MD 2122	-9
Baltimore, MD permit, Pages I and 2 sht pearment of Health and Important: If item 27 is injury or other traumati	20a. Method of Disposition 20b. Place of Dispo	2 Carriage Court Baltimore, MD 2122 position (Name of cemetery, Date 20c, Location - City or Town, State	)
Ore		Gifts Registry March 18,2008 Hanover, MD	[
timenitiment y or o	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Anatomy Gifts Registry	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important! If item 27 is m injury or other traumatic.	113	522 Congelley Drive Suite P. Hanover MD 2	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac or respiratory arrest, shock, or heart lerotic Cardiovascular Disease Complicated Between	nate Interval n Onset and
/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line by izure Disorder Immediate Cause (Final disease a.	Lagrant is Di person	Death
aminer	or condition resulting in death)  Due to (or as a consequence of):		
	Sequentially list conditions,  If any leading to immediate  Due to (or as a consequence of):		
gi	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause		
ed nsit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
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O,  be execut sician and burial - tra	X UNPENDED AMENDED 23a, Pt 11, 27, 28a-	23d. Date of delivery	
Box 6876C c death certificate the attending phyself for use as the b	IF FEMALE: 23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregnancy Month Day	Year
× 6.	past 12 months?  4 Pregnant at time of death 5	Other (Specify)	
Bo he deal the al	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	of death?
Division of Vital Records, P.O. Be tall or Attending Physician: The law requires that the de rs after death.  "al Director: After this certificate has been signed by the line in by the funeral director, page 2 should be detached for the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present of the present o		1 Yes 2 No 3 Probably 4	<b>✓</b> Unknown
S, Fluires applies and be	Drowning	24a. Was an 24b. Were autopsy findi autopsy prior to completion	ings available
orc aw recas be		performed? death?	2 No
Rec The licate		1 Yes 2 No 1 Yes 26.Place of Death (Check only one)	2 110
ician:	25. Was case referred to medical examiner? Hospital: 4 Inpatient 2 FR/Outpatie	low-	
f Vi Physi er this	27 Manner of Death 28a Date of Injury 28b. Time of		Bathtub
nding nding th.	1 Natural 5 Pending Fnd 3/12/08 unk	1 Yes 2 A No Full of water	
iSiC	2 X Accident Investigation 3 Suicide 6 Could not be	treet, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State) 5322 Carriage Col	Number, City
Div ital or urs aft	determined (Specify)House	Baltimore, MD	
		ocurred at the time, date and place, and due to the cause(s) and manner as stated.	s)
To the within To the comple	and manner stated.	igation, in my opinion, death occurred at the time, date and place, and due to the cause(s	
	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, 10) O.C.M.E. March 13, 2008	
	tamen & yuthall, mis	O.O.IVI.E.   Mid. 61. 75, 2233	
_	30. Name and a drass of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201	
	31 Date filed (Menth Day Veer) 32 Registrar's Signature		
Sta Registr	te 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2008 March 5, **Physician** Helen H. Goss 12:05 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 11029 Webster Drive Calvert Lusby | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Cay, Year) | Dec 29, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2♥ F Maryland 212-20-1740 Yrs. Director 84 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other then "natural", or flems 23s or 28s-f ehow 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Madical Example must be notified at 1 ☐ Yes 2 ☑ No Calvert Lusby Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 20657 11029 Webster Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: Specify: white Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Edward Hance Hazel Elizabeth Hutchins ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
eny injury or other treu Joan Ronbeck/daughter 11029 Webster Drive Lusby, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Licensee S. Wade, Director 21. Signalura of Funeral Service State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** & METASTATIC SQUAMOUS CFIL LUNG YFAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď D11 2000 UBSTEUCHT VE 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Besidence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ +16 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerel ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 226358 MARCH 12,2008 12 30. Name and a ress of person who complet cause of death (Item 23a) (Type, Print) 110 D-5017-310-Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 8 2008 State Boske

DHMH 17 Rev 1/2001

Registrar

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 135 Louise Terrace 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Processing 17. Father's Name (First, Middle, Last) Be George Clinton Williams 19a. Informant's Name/Relationship (Type. Print) Mrs. Mary Ann Dill/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 19. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee aveur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) rulmone UV Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or an an uence of: Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes Z No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes Completed 24a. Was an autopsy performe completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a, Certifiei (Check only one) 29c. License number 29b. Signature and title of certifier

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 16^{Day} 2008^{Year} **Physician** Gloria 9:00 P M .Tean Gatton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 16,1944 Birthplace (State or Foreign Country)
 OU 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 F 64 OH 283-46-7536 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. 14 Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Jetsort 18. Mother's Name (First, Middle, Maiden Surname) Pauline Adline Breech 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Louise Terrace Glen Burnie, MD 21060 20c. Location - City or Town, State Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation [0/35] Services 1 2nd AVenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death Leen 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1☐ Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 106 Glen Burnie MD 21061 S. Crain 31. Date filed (Month, Day, Year) 600 MD 32. Signature State MAR 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 📋 🦙

DHMH 17 Rev 1/2001

Registrar

To the Hospital within 24 hours a To the Funeral I

2008

08-02092	
Teresa Grandy	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar		Certificate of D	eath		Reg. No.			
Physician/	1. Decedent's Name (First, Mid		C			2. Date of Death Month Day Year 0715 bro			
Medical Examiner	1-1	RESA	UR/	City, Town/or Lo	March 15, 2	2008 4c. County of Deal	0715 hrs		
	4a. Facility Name (if not institut 2340 Sidney Avenue			city, Townyor Lo Baltimore	caudii di Death		AT.	/A	
Funeral	Social Security Number			f Under 1 Year	If Under 24Hrs	. 8. Date of Birth		irthplace (State or	
Director	220-80-1472	1 M 2 KF	47 Yrs.	Months Days	Hours Min.	Trik 5	4 1960 Fore	ountry) MARYLAKO	
	Usual Residence of Decedent		, ,			NUMER	11.100		
/ any	10a. State 10b. Count	10	c. City, Town or Location	10		~		10d. Inside City Limits	
daryland 28a-f show 1 at once. ector	MARVLAND	N/A		BAL	TIMOR	RE CI	TV	1 XYes 2 No	
the Marylan a or 28a-f st tiffed at one Director	10e. Street and Number		1	of. Zip Code		10	g. Citizen of What Co	untry?	
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ems 2	11. Marital Status 1 Never Married 2	12. Was Decedent Ev Armed Forces?		ecedent of Hispa specify Cuban, N		ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,	
er death with t	3 Widowed 4 D	1 Yes 2 X	No I	es 2 X No	snec <i>i</i> fu:		Specify: B	IANV	
ural"	15 Decedent's Education (St	or Dates:				work done	16b. Kind of Business	ZACK s/Industry	
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exaut Completed	Elementary/Secondary (0-12		during most	of working life. D	O NOT use reti	red)			
5-0036 lied within 7 Hygiene. I other than the Medica	12 +HGRADE	<u>.</u>	LAU	NDRV	WOR	RKER		NIFORM	
Hygie W Hygie Co	17. Father's Name (First, Midd	e, Last)	^ .	18	.Mother's Name	(First, Middle, M	aiden Surname)		
21215-0036 21215-0036 Suld be filed within 7/ Mental Hygiene. I marked other than it event, the Medical To Be Comple	CHARLI	E (	19b. Mailing A	ddaga (Ctarata	TEA	RL Dural Bauta Numi	per, City or Town, Sta	ROWN	
O 8 5 2 2 1 C	19a. Informant's Name/Relatio	REGOR II DAUGH		A LL		- 5	LTIMORE I		
ore, MEss 1 and 2 s of Health as If item 27	20a. Method of Disposition	KEGUR II UZHUOTI	20b. Place of Disposition		LTON Setery,	Date/	20c. Location - City		
More Pages 1 ent of B unt: If i		on 3 Removal from State		100	-01 01	-21-10	10100	11/- 11/	
Baltimore, permit. Pages 1 a Department of He Important: If He injury or other tr	21. Sig ature of Funeral Service	Specify:	MT. 7101	ne and Address o	Facility (1)	-20-08	LANSLO	RAL HOME	
Balti permit. Departm Imports	Tachedaso	1 Mare	7	e and Address of	FULTON		BALTIHON	RE MO21217	
Physician	23a. Part I Enter the disease,		e death. Do not enter the	mode of dying, si	uch as cardiac o	or respirator arre	st, shock, or heart	Approximate Interval Between Onset and	
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<b>t</b>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):						
min view	cause. Enter Underlying Cause (Disease or injury that initiated	e c							
led · Insit	events resulting in death) Las	Due to (or as a consequ	uence of):						
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). Box 68760, the death certificate by the attending physic ched for use as the bur Physician/Mec	1 Yes 2 No 9 🗸	nknown g Unknown	ne of death 5 Othe	(Specify)					
ords, P.O. Box 68' w requires that the death certification is been signed by the attending should be detached for use as inleted by Physician.	Part II. Other significant con-	litions contributing to death b	out not resulting in the unc	erlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death.  "In Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detach ertification: To Be Completed by P	î					1 Yes	2 No 3 P	robably 4 🗹 Unknown	
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e law e has ge 2 sh						perfor	med? death	?	
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should in: To Be Complete		cal		26.Place o	of Death (Check			100 2 100	
Vital sysician this cert director	examiner?	Hospital: 1 Inpatient	2 ER/Outpatient	DOA C	Other Nursi	ng Home 5	Residence 6 🗸 Ot	her: Scene	
of ng Ph	27 Manner of Death	28a. Date of Injury (Month, Day,Yea	28b. Time of Inju			28d. Describe h	now injury occurred		
itendi teath. tor: /	1 Natural 5 Pe	ending Found 3/15/		am 1 Ye	es 2 X No	Unknown			
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 X C	ould not be 28e. Place of Injur	ry - At home, farm, street,	factory, office bu	ilding, etc.	28f. Location (S or Town, S	Street and Number or tate) 2340 Sidn , MD	Rural Route Number, City  ev Ave.	
Spital spital hours of fillec	4 Homicide  29a. Certifier 1 Certifying	termined (Specify) Found							
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as redical Certification: To Be Completed by Physician	(Check only 1 Certifying one) 2 Medical E	Physician: To the best of my kaminer:On the basis of exami	knowledge, death occurre nation and/or investigation	d at the time, dat n, in my opinion,	e and place, an death occurred	d due to the caus at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)	
To the Ho within 24 To the Fr complete!	29b. Signature and title of cert	and manner stated.	-	29c. License			29d. Date signed (/		
	D. A.	, D	00 -	O.C.M			March 15, 200	8	
	30. Name and address of pers	on who completed cause of dea	ath (Item 23a)						
- Ø	Patricia Aronica-Pol			11 Penn Str	eet, Baltimo	re, MD 2120	1		
State			Signature						
Registra	MAR 18	. 2008	The first	<i>y</i>			<u> </u>		
DHMH 17 Rev 1/2001			ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28b per me, g877, U3/18/U8dhb.
Certificate of Death Reg. No. Reg. No∠ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9337M erman GIDSON Narch 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manyland Medica more Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months Days Hours 219-14-7914 85 Director 11/11/1922 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at 1 ☐ Yes 2X No Director MD CARROLL SYKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r Items 23a or 2 iner must be n 5561 SYKESVILLE RD. 21784 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW I I 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2X Married ö 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STATE GOVERNMENT 12 SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Menta Item 27 is marked HERMAN C. GIBSON NELLIE ALLEN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5561 SYKESVILLE RD., SYKESVILLE, MD 21784 MARY GIBSON - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State WESTMINSTER CEM 3/15/08 WESTMINSTER, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityFLETCHER FUNERAL HOME, P.A. 21. Signature of Funeral Service Ligenses 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician WHI resulting in death) /Medical ue to (or as a consequence of): Examiner DENTIFICATION APPROVED BY REDICAL EXAMINER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA ۴ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 1 🗆 Natural 5 ☐ Pending investigation (Month, Day To the Hospital . . . within 24 hours after death.

To the Funeral Director: Aft Unknown 05/08 1 Tyes 2 No nome 2 Accident latert 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8235

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State Registrar 22

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dabbs

31. Date filed (Month, Day, Year) MAR 1 8 2008

		-	For State Registrar	State of Maryland		rtment of H			giene	08	08732	
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)	Gillan				2. Date of Dea Month	Day	83	3. Time of Death 6523 M	
	Examin Funeral	er	5. Social Security Number 6. Sex	reet and number)  O'CE HOS Di-  7. Age (In )rs. las  M 2 F 62	t birthday) Yrs.	4b. City, Town, or R O S (If Under 1 Year Months Days	Location of Death  Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color	8. Date of Birtl	r, Year)	9. Birthpl		
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	cation		Nov.7	1945		ryland Od. Inside City Limits	
	the mary	ector	MD Baltim	nore		Esse	X		1 ☐ Yes 2 🛣 No			
	a o	<u></u>	2 Villa Capri C	Circle		21	221		USA			
2	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural; or terms 23a or 28e-f show event, the Medical Examination must be indifficat at	by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or North Hispanic Origin?)     1 □ Yes, specify Cuban, Mexican, Puerto Rican, etc.)					ce - Americ ck, White, fy: Wh:		
0000-01717	within /2 hou ene. then "natura ha Medical E	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of will life. DO NOT use retired)  Owner			king	Gas S Laund	tatio	on	
<u> </u>	ould be tiled within Mental Hygiene. arked other then ' etic event, the Me	Be	17. Father's Name (First, Middle, Last)  Charles McD. G	2412				ne (First, Middle, y Schen	Maiden Surna			
7	should be ind Mental s marked ( umetic ev	5	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street	and Number or Ru	iral Route Numbe	er, City or Town	, State, Zip	Code)	
	Health a tem 27 is other tree		Dolores Harris  20a. Method of Disposition  1 🖾 Burial 2 🗆 Cremation 3 🗆 Re	000	ce of Dispo	illa Cap sition (Name of natory or other place sary Cen	-01	Date	20c. Location	- City or To	own, State	
baltimore,	permit. Pages Department of Importent: If i any injury or a		4 □ Donation 5 □ Other (Specify)  21. Signatu 1 Funeral Service License			. Name and Addres	ss of Facility 3	00 Mace	Ave.	Balt	imore MD	
ر ، م	wedical / Medical  Icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conseque	nce of):	tic Co	CO 10Vo	56419	r Dise	2450			
.O. 10.	The law requires that the dea h certificate ten been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3	Ectopic pregnancy Other (specify)	,			ate of delivers	ery Da _j Year	
ָר עט, ר	uires that signed by	by	Part II. Other significant conditions conf	tributing to death but not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did t		ntribute to t 3 ☐ Prol	he cause of death?	
		Completed						1 Yes	psy ormed? 2 \( \text{No} \)	were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of	
VII		o Be	25. Was case referred to medical examiner?  12 Yes 2 \( \text{No} \) No	ospital: 1 ★Inpatient 2□E	R/Outpatier	nt 3 DOA Oth	00	ath <i>(Check only o</i> Home 5 ☐ Resi		ther (Speci	fy)	
5	ding h. After fune	-	27. Manner of Death  → Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o Injury	f 28c. Injur	y at	28d. Describe	how injury occ	urred		
DIVISION	in Sire	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				City or To	wn, State)		al Route Number,	
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one) Certifying Phys	sicien: To the best of my knowner: On the basis of examination and manner stated.	rledge, deat on and/or in	vestigation, in my	opinion, death occ	e, and due to the urred at the time,	date and place	e, and due t	to the cause(s)	
	To the within 2 To the comple	M	29b. Signature and title of certifier	Cab		29c. Licens	9 448		3/14	Month,	Day, rear)	
	lo		30. Name and address of person who con	ode 9000 I	coat	Lin Sai	iare Dr	ve Bal	timore	2, M	D 2123-	
	St. Regist	ate	31. Date filed (Month, Pay 8 2008	a2 Registrar's Signatu	ure							

DHMH 17 Rev 1/2001

Physici /Medio	an al	A
Examin	er*	4a.
or 28a-f show	Director	5. 2 Us 10 M 10 7
Department or result are weither hygeric actural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral [	
Department or result and warran rygene. Important: If them 27 is marked other than any injury or other traumatic event, the M once.	T	17 G 19 C
important any Injury once.		21
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o the Funeral Director; After this certificate has been signed by to on the Funeral Director; After this certificate has been signed by to onpletely filled in by the funeral director, page 2 should be detach	fedical Certification: To Be Completed by Phys	27
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o the	Mec	29

**Funeral** Director

For	State of Marylar				and M	lental Hy	giene	9 0	0.0	00	700
Registrar		Cer	tificate (	of Death			Reg. No	K U	UO	U 0	100
Decedent's Name (First, Middle, Last	⁰					2. Date of De Month	eath Da	ay	Year	3. Time o	
ANNA		T	# 07 T	GOELLE		MARCH	14		2008	9:15	д М
4a. Facility Name (If not institution, give				vn, or Location of	of Death		40	. County	of Death		
Johns Hopfins BANIEW  5. Social Security Number 6. Se			If Under 1 Y		24 Hrs.	8. Date of Bir	rth		9. Birtho	lace (State	or Foreian
	7 M 077 F	84 Yrs.	Months Da	ays Hours	Min.	(Month, Da November	ay, Year,	1923	Mary	try) _	
Usual Residence of Decedent											
10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						1	0d. Inside (	City Limits
Maryland Baltimor	:e	Dunda.	lk								
10e. Street and Number			10f. Zip Co				10g. Ci		What Coun	itry?	
7124 Railway Avenu		10		21222				US	SA ce - Americ	on Indian	
11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Year or Dates:		rvas Decedent fYes, specify 1 ☐ Yes 2 🔀	of Hispanic Ori Cuban, Mexicar No Specify:	gin? (Sp. i, Puerto	ecity Yes or No Rican, etc.)	0-		ck, White,	etc.	
15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual O	ccupation	t of work	ina	16b. K	Kind of B	usiness/Ind	dustry	
Elementary/Secondary (0-12)	College (1-4or 5+)			one during mos etired)		g					
8 years		Hous	sewife	40 Matha	wa Mami	e (First, Middle		wn H			
17. Father's Name (First, Middle, Last) George William Tal	bott Sr.					na Man			ne)		
19a. Informant's Name/Relationship (T	ype. Print)	19b. Mailin	g Address (St	reet and Numbe	er or Run	al Route Numb	ber, City	or Town,	State, Zip	Code)	
Calvin Goeller	Husband			y Avenu						1222	
20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	Place of Dispo cemetery, cren k Lawn	natory or othe	r place)   [V	larch 2008	Date 1 17,			- City or To		
21. Signature of Funeral Service Licens	7	Ĉ	Name and A	ddress of Facility Funera	і но	ome Of 1	Dund	alk,	P.A.		
23a Parti Enter the disease or comp	olication that caused the dea	/	110 SOT	lers Po	int	Road,	Dund	alk,	Mary.	Approxima	
23a. Part1. Enjer the disease, or comp ship heart failure. List only c Immediate Cause (Final	1.75 <u>1</u>			jg,						Interval Be Onset and	etween
disease or condition resulting in death)	a. PHEVMANIA								2	NEE NEE	K3
	Due to (or as a consec	quence or):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or jury that initiated events	b. Due to (or as a consec	quence of):									
cause. Enter Underlying Cause (Lisease or in jury) that initiated events	0								- 4		
resulting in death) Last	Due to (or as a consec	quence of):									
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IF FEMALE:											
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a 9 ☐ Unknown	aldeath 3□	Ectopic pregr Other (specii				Ì		te of delive onth	ery Day	Year
Part II. Other significant conditions co	ontributing to death but not res	sulting in the ur	nderlying caus	e given in Part I		23e. Did	tobacco	use con	tribute to tl	ne cause of	death?
						1 🗆	Yes 2	2□ No	3 ☐ Prob	ably 4 🔀	Unknown
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25. Was case referred to medical				26. Place	of Deat	1  Yes h (Check only		<u> </u>	. 🗆 163	-17.40	
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 X Inpatient 2 □	] ER/Outpatien	t 3 DOA	Other: 4 🗆 Nu	rsing Ho	me 5 ☐ Res	idence	6 □Otl	ner (Specif	iy)	
27. Manner of Death  1   Natural  5   Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe	how inju	ary occur	rred		
2 ☐ Accident investigation			М	1 ☐ Yes 2 ☐	No						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	iome, farm, str	eet, factory, of	fice		28f. Location ( City or To			ber or Rura	al Route Nu	mber,
	ysician: To the best of my kni liner: On the basis of examin and manner stated.										e(s)
29b. Signature and title of certifier	and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t		29c. Li	cense number			29d. Da	ate signe	ed (Month,	Day, Year)	
Yalau Ath			b=	3-000			MARI	LLI	14.20	078	
30. Name and address of person who co	completed cause of death (Ite	m 23a) (Type.		,-000			the first transfer	<b>-</b> F1	17, 20		
EDWIN OSTRIN, MO, PI				ALTIMORE	. м.	ARYLAND	> 2	2122	1		
31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	N -	211.00.	1				*		
MAR 1 8 200	8 Ellenge A	5 600	all.								

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 7 per fth 8877 3-24-08 vt.
State of Maryland 7 bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** HIONZO 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Re hab Ctn NUrsing ltimore If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Ye 7/28/56 Birthplace (State or Foreign Country) **Funeral** Months Hours Davs 1 3 M 2 □ F 51 Director 218-64-1236 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any july or other traumatic event, the Medical Examiner must he maiting any in 10a. State MD 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A Yes 2 No **Funeral Director** Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1217 Harlem Avenue 21217 USA Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Spec African 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Hopkins Izola Griffin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5503 Lynview Ave, Balt., MD 21215 Gracey Griffin/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem, . 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/17/08 Mt. Baltimore,MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs, PA 21. Signature of Funeral Service Licens 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heguired mmune disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner stina Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 🛱 No certificate 1☐ Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 Amaten Al Koon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 Dolphin Street AMATUN NAFEM

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2008 11:33 P M Frances Hughes Hopkins March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 💟 F 85 Yrs. Months 220-20-7287 **Director** Aug 25, 1922 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Bel Air Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 USA 226 F Crocker Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced er than "natur ; the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fii and Mental H Is marked ott Be Thomas Hughes Anna Florence Wheeler ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra Miles B. Hopkins, Husband 226 F Crocker Drive Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Inc. 03/18/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Uensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** aARTERIOSCLEROTIC GARDIOVASCUL disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physiciam and for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE PULMONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 W Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed

Baltimore,

850(

48

08

3/15/

HOPKIN

**Division** 

68760,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BEL AIR MD 21014

29a. Certifier (Check only one)

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AVE

29b. Signature and title of certifier

29c. License number D25027

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

MAR 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined



within 24 hours a

To the Funeral I

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 March 6:15 A M Barbara Houart /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 12, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1945 1 □ M 2 F 193-34-7763 62 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Arnold Director Maryland Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21012 1502 Sillaman Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = 2∑ No If Yes, Give Year or Dates: 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Taddei Rose Lusky 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Houart, Husband 1502 Sillaman Court Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or conce, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 03/14/08 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Charsee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each migh. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performe certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled it 1 Ercertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of who completed cause of death (Item 23a) (Type, Print) 20902 10301 Georgia Avenue Suite 205 Silver Spring, MD Charles Boice 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** HEALEY MARC 14 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A JOHNS HOPKINS BAYVIEW HEDICAL EACTIMOKE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Sex 1/1 M **Funeral** Months Days Hours JUL 15, Year 48 2∏ F 59 212-52-3619 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Dunda1k MD Baltimore 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 **USA** 76 Dundalk Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black White etc. 2 should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2♥ No White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Handyman 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Marie Ruby Robert Leo Healey, Sr. 19a. Informant's Name/Relationship (Type. Print)
Deborah A. Sauer/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is 7344 Norris Avenue, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 3/15/08 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 21. Signature of Funeral Service Licensee C. Todd Dring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) PNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner the burial-transit and resulting in death) Last that the death certificate be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the ar 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown After this certificate has been si funeral director, page 2 should h Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No i or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Funeral Director: completely filled in by the t 6 ☐ Could not be determined 3 ☐ Suicide 28e_ Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

EASTERN AVENI

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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KATIMOKE MD

14,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Voar **Physician** Hoen Doro thy 10:45 PM moud 2005 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dalhmore Cromwell Parksilu Genesis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 🔀 F 005-20-9516 80 June 20, Director Connecticut Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Itams 23a or 28a-1 show the Medical Evantiner must be notified at MD. Baltimore Baltimore 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code WIT 2406 Ellis Road 21234 USA death 1 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If tian 27 la marked other then? any injury or other traumation. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2 No f Yes. Give 1 Never Married 2X Married 1 ☐ Yes 2 ▼ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry At Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy A. Lawrence Douglas Eldredge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leonard S. Hoen/ Husband 2406 Ellis Road Baltimore, MD. 21234 20b. Place of Disposition (Name of cemetery crematory or other place)
Evans Funeral Chapel Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 03/19/08 ForestHill, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign, ture of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Venenha 41945 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Box 68760, Due to (or as a consequence of) affending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dm 1 Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificafe 1 ☐ Yes 2 ☐ No HTN 2 - No ecfor, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 2 this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification:

Division of Vital or Attanding Physician: After thi I Diractor: A d in by the fo

within 24 hours a To the Funeral I To tha

State Registrar 1 Natural

2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

determined

Klux no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 H Charles St Svite 4200 wend 31. Date filed (Month, Day, Year) 32. Signature

2008



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

D 31295

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

08-02074 John Louis Hanges

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Offit Louis Flange.	1-	For State Criticate Consistrar	f Death	Reg. N		
Physician	_	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day March 14, 200		Time of Death
Medical Examine		John Louis Hanges	4b, City, Town, or Location of Death		J8 4c. County of Death	
	4.	Facility Name (if not institution, give street and number)     1000 E. Joppa Road	Towson		Baltimore Count	ty
Funeral	- 5	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth(M	M/DD/YYYY) 9. Birthp	lace (State or
Funeral Director	2	12-28-5253 1X M 2 F 77 Y	Months Days Hours Min	02/12/19	31 Foreign Coun	try) MD
any	<u> </u>	Sual Residence of Decedent   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town or Local   10c. City, Town o	ation		1	0d. Inside City Limits
*	1	MD Baltimore	Towson			1 Yes 2 X No
Aaryland 28a-f show		0e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Countr	y?
the Maryland a or 28a-f sh tified at once	2	1000 E. Joppa Road	21204		USA	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I should be filed within "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	ᇎᅥ	Marital Status     12. Was Decedent Ever in U.S.     13. V	las Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - America White, etc.	n Indian, Black,
death or ite	Funeral	Never Married 2 Marned 1 Yes 2 X No		,	Specify: Whi	ite
Safter Safter	>	3 Wildowed 4 A Divologal	Yes 2X No specify: ent's Usual Occupation (Give kind of	work done 16	b. Kind of Business/Inc	
"matu	ted -	Figure 15. Decedency Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	most of working life. DO NOT use rel	tired)		
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2121 2121 Mental I Mental I marked ic event,	a L	Louis Hanges  9a. Informant's Name/Relationship (Type, Print ) 19b. Mail	Cenia ing Address (Street and Number or	Thomas Rural Route Number	City or Town. State.	Zip Code)
D 2 should and M 7 is m	٦	Total minormality of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	E. Cherry Hill Ro			- 1
mnd 2 sho lealth and 2 tem 27 is traumati	-	20a. Method of Disposition 20b. Place of Disp	osition (Name of cemetery,	Date 20	Oc. Location - City or T	оwп, State
TOFE ages 1 at of H t; If i	- 1	1 Burial 2 X Cremation 3 Removal from State crematory or	· · · ·	/17/08	Hampstead.	. MD
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If tiene 27 is injury or other traumatic	H		. Name and Address of Facility		Reistersto	
Dep Dep Injury		Sam & Olive 18	line Funeral Home	e Reiste	rstown, MI	21136 Approximate Interval
Physician	7	2 a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line Atherosclerotic card	rthe mode of dying, such as cardiac iovascular disease co	or respiratory arrest, mplicated by	snock, or neart	Between Onset and Death
/Medical caminer	- î	Implediate Cause (Final disease a. inhalation, thermal in ju	ries and alcohol use			Death
		b				
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
	Εij	Coisease or injury that initiated events resulting in death) Last				
		d	NE 070 / // /00			
be exection a sician a	Medical	X UNPENDED AMENDED 23a,27,28a-f per	ME g8/8 4/4/08 amn			
760, icate by the bu		IF FEMALE: 23b. Was decedent pregnant in the 2.1 Live birth 2.2	Fetal death 3 Ectopic preg	nancy	23d. Date of delivery  Month D	ay Year
c 68	ciar	past 12 months?  4 Pregnant at time of death 5	Other (Specify)	•		
Box 687 e death certific the attending I ed for use as th	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		23e Did toba	cco use contribute to	the cause of death?
.O. hat the	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		2 No 3 Prob	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rape death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	E E			24a. Was an	24b. Were au	topsy findings available
cord aw rec aw rec as bec 2 shou	Completed			autopsy perform	ed? death?	ompletion of cause of
Rec The l	5		26.Place of Death (Chec	1 Yes 2	No 1 ✓ Ye	s 2 No
Vital Recc ysician: The lav his certificate ha director, page 2	BB	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpat	I Othor:		esidence 6 🗸 Other	: Scene
1 of Villing Physic	e.	1 ✓ Yes 2 No Impatient 2 ENCOUPAR  27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time		28d. Describe ho	w injury occurred	
on c rading ath.	틶	Natural 5 Pending 2/1//00 11.25	am 1 Yes 2 X No	Victim of	house fire	
livision I or Attendi after death. Director:	<u>i</u>	2 X Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (Str or Town, Sta	eet and Number or Ru te) 1000 E Jopj	iral Route Number, City Da Road
Oirs ar	Certification:	4 Homicide determined (Specify) Residence				
		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigation.	ccurred at the time, date and place, a tigation, in my opinion, death occurre	ind due to the cause( d at the time, date ar	s) and manner as stat nd place, and due to th	ea. le cause(s)
To th within To th	Medical	2 weetcal Examiner. On the basis of examination allows and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
		290. Signature and the or certains	O.C.M.E.		March 15, 2008	
T V X		30. Name and address of person who completed cause of death (Item 23a)				
Folar		Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201		<u> </u>
St	ate	31. Date filed (Month, Day, Year) 32/Registrar's Signature	aste			
Regist	rar	MAR 1 8 2008 Allegar DE A				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #19a Per Ana Bd G877 3/19/08 JH Certificate of Death Red. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mary Renee Y. Heck 2008 /Medical 4c. County of Deat 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day 1923) Year **Funeral** Months Days Florida 1 ☐ M 2 🛛 F 84 217-16-8212 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 1 ☐ Yes 2 No Department of Health and Mental Hygjene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumattc event, the Medical Examiner must be notifled. Anne Arundel Pasadena Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21122 220 Maryland Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married white altimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) filed within Hygiene. social services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ollie Virginia Howey Robert Lee Bonneville ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21122 220 Maryland Avenue Pasadena, MD Roland Heck/spouse son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street Ronal Serv S. Warde de Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** inTracerebral /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2[] No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Inpatient Medical Certification: To this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director; filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State Registrar 30. Name and ad

Date filed (Month, Day

Operin

8 2008

erson who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

Physician /Medical Examiner
Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

ical		Matabel	Sally H	Hammond							03-13	-200	8		7:30	$P^{M}$
iner	A.	4a. Facility Name (	If not institution	n, give street and nu	mber)			4b. City,	Town, or	Location of Dea	th	4	c. County of De	ath		
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Т		5. Social Security N		6. Sex	7. Age	(In yrs. last	birthday)	If Under	r 1 Year	If Under 24 Hrs	8. Date of E	lirth			ce (State or	Foreian
		215-22-5	902	1 □ M 2 🔼 F		30	Yrs.	Months	Days	Hours Min	(Month, L			Country	MD	
	-	Usual Residence of			(	50					07-19	-192	/		FID	
	-	10a. State	10b. County			10c. City, T	own or Lo	cation		-				10d	I. Inside City	y Limits
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	(	10e. Street and Nu	mber					10f. Zip	Code			10g. C	citizen of What (	Country	?	
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١	2	11. Marital Status		12. Was Dec Armed Fo	edent Ev	ver in U.S.	13.	Was Dece	dent of H	lispanic Origin? (	Specify Yes or N	10-	14. Race - An			
ū	3	1 Never Marr	ned 2 Marr	nied 1 □Yes	2 🔀 No						to rican, etc.)		Black, Wh			
2	5	3 🙀 Widowed	4 Divorced	If Yes, Gi Year or D	ve lates:			1 ☐ Yes	2 <b>)</b> (1 No	Specify:			Specify:	W	hite	
Be Completed by Finneral Director	3	_	15. Deceden	t's Education		1	6a. Dece	dent's Usu	al Occup	ation		16b.	Kind of Busines	s/Indus	stry	
1 6				st grade completed)			(Give life. l	kind of wo DO NOT u	ork done o se retirec	during most of wo	rking	+				
[		Elementary/Seco	ondary (0-12)	College (	1-40r 5+,		Busin	ess (	)wneı	r		R	eal Est	ate		
ĮČ	•	17. Father's Name	(First Middle	Last)						18. Mother's Na	me (First, Midd	le. Maide	en Surname)			
l m	í	Arthur Ba								Regina		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Ę	2															
		19a. Informant's N	ame/Relations	ship (Type. Print)			19b. Mailir	ng Address	(Street	and Number or F	ural Route Num	ber, City	or Town, State	, Zip C	ode)	
		Mrs. Sal.	ly Tayl	lor / da	iught	ter	1420	Crai	in Hv	лу S.; G	len Bur	nie,	MD 210	61		
1		20a. Method of Dis		_		20b. Place	e of Dispo	sition (Nar	me of	ce)	Date	20c.	Location - City	or Town	ı, State	
		1 ☑ Burial 2 4 ☐ Donation		3 ☐Removal from	State	1		-	,	ark 03-1	7-2008	G1	en Burni	ie.	MD	
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	+		m-			2411				SW; Gle			D 21061		Servi	
		shock, or Nea	th∉ disease, or art failure. List	complications that of only one cause on o	caused ti each line	he death. I	o not ent ∕i	er the mod	de of dyin	ng, such as cardia	ic or respiratory	arrest,		lr.	pproximate terval Betw	veen
	1	Immediate Cause disease or condition	(Final	AA	ml	til	Le	An	reli	ma				0	nset and D	9.1 1
		resulting in death)		Due to	(or as a	consequen	ce of);		1					- 8		
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à	,	Sequentially list confirming to incause. Enter Under Cause (Disease or	onditions,	b. Due to	for as a	Consequen	CE OF		***							
Fxaminer		cause. Enter Under Cause (Disease or	erlying -	<												
162		that initiated events resulting in death)	S	C. Due to	(or as a	consequen	re of):							+		
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vsician/Medical				d										+		
Jan S	+	IF FEMALE:												-		
2	1	23b. Was deceder		23c. If yes, ou	tcome pl	f pregnancy ! □ Fetal de	/	Ectopic p	rognanov	,		13	23d. Date of o	lelivery		
		in the past 12 1 ☐ Yes 2		4□Preg	nant at ti	me of deat		Other (sp					Month	D	ay Y	ear
S		9 Unknowr		9□Unkn	iown											
à	: [	Part II. Other signi	ificant condition	ons contributing to d	leath but	not resultin	ng in the u	nderlying c	ause giv	en in Part I.	23e. Dio	tobacco	use contribute	to the	cause of de	eath?
þ											10	Yes	2)ANO 3	Probah	iy 4 □Ui	Inknown
ted													T	1 TODGE		
nie	2										24a. Wa	s an opsy	24b. Were	autops	y findings a letjon of ca	available
Completed											per	formed?	death'	?	No No	1030 01
C		25. Was case refer	rred to medica						Service.	26 Place of Do	1  Yes ath (Check only		101	-	ALIVO	
Be		examiner? 1 ☐ Yes 2	ř	Hospital:	Innations	م ا ا	/Outpatier	4 2C D	Oth	or.			- Day 10			
F	ŀ	27. Mapper of La	-	28a. Date	Inpatient		b. Time o		28c. Injur	4 Li Nursing	28d. Describe		6 □Other (Sp	pecify)		
0		Natural	5 Pendin	ng (Mor	nth, Day	Year)	Injury		Worl	k?	260. Describe	e now m	ury occurred			
i i		d Accident	investig 6 ☐ Could	not be				М		Yes 2 □ No						
Ė		3 ☐ Suicide 4 ☐ Homicide	determ	inad Zoe. Place	e of injuกุ ling, etc.	y - At home (Specify)	, farm, str	eet, factory	y, office		28f. Location City or T	(Street own, Sta	and Number or ite)	Rural F	łoute Numb	ber,
Certification: To				- 1									,			
1 6	5	29a. Certifier	1 Certifyir	ng Physician: To the	e best of	my knowle	dge, deat	n occurred	at the tir	me, date and place	e, and due to th	e cause	(s) and manner	as stat	ed.	
Medical		(Check only one)	2 ∟ Medicat	Examiner: On the band man	nasis of e nner state	examination ed.	n and/or in	vestigation	i, in my c	opinion, death occ	curred at the tim	e, date a	ind place, and d	lue to ti	ie cause(s)	)
Z	1	29b. Signature and	title of certifie	F				290	c. Licens	e number		29d. E	ate signed (Mo	nth, Da	ıy, Year)	
		►C0	and	any 1	V 1-	ソ			1	29500	_	MAG	mrh 1	4	2008	2
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ate		31. Date filed (Mor	oth, Day, Year)	0 2000	Registrar	's Signature	2	1	8							
rar			MAK	K ZUUd	18 mil.	2000	7 /	Toral.	· ·							

Registrar
DHMH 17 Rev 1/2001

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM#7 per FH C877 3/21/08 VS

AMEND TITM#7 per FH C877 3/21/08 VS

23a State of Maryland / Department of Health and Mental Hygiene

Amend Items 25,27,28a-f per per 2877 03/14/08dhb

Reg. No 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Willie, James, Horne
4a. Facility Name (If not institution, give street and number) 03:00 March 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore
Under 1 Year | If Under 24 Hrs. VA Medical center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 76<del>.77</del> Director 3-19-1931 N.C. 220-20-6493 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show odi: al Examiner must be notified at 1 √Yes 2 No Funeral Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1308 Walters Avenue 21239 S A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. t⊕Yes 2 No FYes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 12th grade ___ College Heaterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Chester Horne Tessie Monroe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louellen Horne-Wife 1308 Walters Avenue Baltimore, MD 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State ↓ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3-13-2008 Owings Mills, MD Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East W 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia /Medical Due to (or as a consequence of): Examiner Renal Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a sonsequence of) The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Sub-dural hematoma 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy ormed? 2 ☑ No Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes <del>2</del> No 1 npatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 XNo Subject fell in bath tub 03/2008 death. 2 Accident Unknown M hin 24 hours after death the Funeral Director; filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1308 Walters Ave. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Home Baltimore, MD To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) MD AU4176435 W17471 March 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wermine MD, 22 S. Greene St, Baltimore MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 11 13 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 200^{Year} **HOFFMAN ELEANOR** 4:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** JEWISH CONVALESCENT & NURSING BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/12/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛣 F MD 059-16-6651 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD BALTIMORE **PIKESVILLE** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7920 SCOTTS LEVEL ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify Completed by 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** WHOLESALE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SOLOMON KOREN JENNIE MARGOLIS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHAYNE HOFFMAN / DAUGHTER 22 RAINBOW RIDGE DRIVE, LIVINGSTON, NJ 07039 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BETH TFILOH CONG.03/16/2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 oresilie 15min /Medical Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or any consequence of): and Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pt IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Ves 2 certificate has page 2 1□ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manper of Doth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending Injury n 24 hours after death.

Re Funeral Director: Af oletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

gistrar's Signature

# /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State show r 28a-f show notified at Director r than "natural", or items 23a or the Medical Examiner must be Funeral Baltimore, Maryland 21215-0036 ģ Completed Be ant of Health and Mental Ht. If Item 27 is marked of y or other traumatic eve ဥ Department of Important: If any Injury or **Physician**

Physician

Decedent's Name (First, Middle, Last)

Belle

Isennock

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Day

Year 2001 3. Time of Death

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death Month Physician /Medical 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. If Under 1 Year rs. last birthday, **Funeral** Months Hours Min 1 M 2 F Yrs. Director 10d. Inside City Limits 10c. City, Town or Location Show 1 ☐ Yes 2 ☑ No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code death 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, el 1 ☐ Yes 2 ☐ No within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 1√0 Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during the DO NOT use retired) 16b. Kind of B 15. Decedent's Education (Specify only highest grade completed) during most of working al Hygiene. or 5+) condary (0-12) 2 should be fi and Mental H is marked of permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Item 27 is marked any Injury or other traumatic evone. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner ete has been signed by the attending physicien end pege 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Sapsis autopsy performed? Yes 2 No 1 🗌 Yes To the Hospitel or ettending Physicien: within 24 hours after death.

To the Funaral Director; After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?
1.★ Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Cert fication: 1 Natural 5 Pending investigation fal 28e. Place of Injury. At home, farm, street, factory, office building, etc. (Specify) 1 | Yes 2 | No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Flural Route Number, City or Town, State) 9/01 L: burny Road Randals Town 4 \ Homicide Nursing Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) MAR 1 8 2008

MD 6 Trumble H: 11 CT. Lutherv: 11e, Md 21093

mpleted cause of death (Item, 23a) (Type, Print)

018667

March 17,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** Arlene F. Johnson 10 2008 3:25a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Marley Neck Glen Burnie If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1□M 2□F MD Director 217-88-3548 52 8-15-1955 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County a or 28a-f show be notified at 1 Yes 2 □ No MD N/A Baltimore Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or ? 21225 USA ral", or items 23a Examiner must b 4114 Audrey Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Black Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) N/A Elementary/Secondary (0-12) College (1-4or 5+) Disabled llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Cager Nora G. Irvins ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 5316 Brookwood Road Balto, MD 21225 Deneen Bias - Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cem 3-17-2008 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) March F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mua **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading termination cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse juence of): Examiner Division or Vital Records, P.O. Box 68760, certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 ☐ Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this in by the funeral 27. Manner of Death 1 ☐ Natural 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it completely filled

Avenue # 231 Annapolis MD 21401 Ridgely Chopra 600 taitya 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of

29c. License number

D57028

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Decederate Name (Post Abdella, Last)   Part icia Kathleen James   2 Dise of Death Deceder Decederation (Post Name (Post Abdella, Last)   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part Icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathleen James   Part icia Kathlee			•	For State of Maryland / Department of Fleath and 1  - State of Maryland / Department of Fleath and 1  - Certificate of Death	vieilla	Reg.	0000	08747
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## 12 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5 State   Security Number   1.5				Patricia Kathleen James			-	8:45 A ^M
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24a. Was an autopsy performed? In yes 2 No 24b. Were autopsy findings available prior to completion of cause of death (Check only one)  25. Was case referred to medical examiner? In yes 2 No 25. Was case referred to medical examiner? In yes 2 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No 27. Manner of Death 1 No	5	een s	ted			1 Ves	2 No 3 P	robably 4 Unknown
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Duilding, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and the of certifier  29b. Signature and due to the cause(s) and manner as stated.  29b. Signature and the of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	2	Atter deat	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office	28f. Loc	ation (Stree	t and Number or R	dural Route Number,
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIVASAIVAM 19114 Philack phia road, Baltmirk 21237  State  8 21. Date filed (Month, Day, Year)  32 Registrar's Signature		Within To th comp	Me	29b. Signature and the of certifier 29c. License number		29d.	Date signed (Mon	th, Day, Year)
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State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		10		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SiUASAiAM 19114 Philadelphia 80ac	d)	Ba	ltimore	-21237
				31. Date filed (Month, Day, Year)  32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MEND TIEM/IOG perFH. C8/8 4/8/08 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:47A Dieter H. Krebs 14, 2008 M March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford County Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 577-58-2127 75 Yrs Director Feb. 12, 1933 Germany Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ırai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No Maryland HarfordCounty Bel Air Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 250 Golden Rain Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ②X No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: White Specify. 000 133766 31415-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Body Shop Automobile 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 is marked any injury or other traumatic evonce. Karl Krebs Agathe Surrey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Erika Dinse (Companion) 250 Golden Rain Lane, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State March 15,2008 | Forest Hill, MAryland Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 term A Los Approximate Interval Between Onset and Death 23a. Part I. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MECHANICAL DISSOCIATION ELGETRO Physician /Medical Due to (or as a consequence of): **Examiner** PNGUMONITIS SPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): SEVENE SEP. Examiner The law requires that the death certificate be executed pnysician and the burial-trans Due to (or as a consequence of): URINDRY TRACT INFECTION Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA P 1 🗌 Yes this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2008 DANUSHA · SIRITHAND, 260 GATEWAYDRIVE, SUITE 21/22B, BELDIR, MD 2/014

31. Date filed (Month, Day, Year)

32 Registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Year) 18 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) KWONG Month Physician GOON 2008 8-15AM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔽 F China 81 Dec. 12, 1926 Director 220-96-5085 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐Yes 2 F No a or 28a-f sh t be notified Director Owings Mills MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21117 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, th. Medical Examiner must b 3 Fairbridge Court Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1∐Yes 2⊠No Baltimore, Maryland 21215-0036 Specify: Specify: Asian þ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lu T. Ng Yiu X. Liu ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Fairbridge Court, Owings Mills, MD 21117 Son San Tak Kwong 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3-18-08 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licenses ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (britis a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes fo the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral of 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier l 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 8 2008 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** March 14, Doris Fosler Kohlhafer 11:46 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Oak Crest Care Center Parkville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth April 11, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🖔 F Maryland 218-03-4404 91 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2 No Director Md. Baltimore Parkville 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a or 2 8832 Walther Boulevard 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 77 is marked other than "natural", or itentraumatic event, the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify Be Completed by 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) School Teacher School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl Burtnett Pearl Rosenstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is, any injury or other trau, once. Mrs. Janice Clark/Daughter 8397 Rodgers Road Lodi, Ohio 44254 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 3/19/08 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Apset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rno pa /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760.

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death

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physician the

Baltimore, Maryland 21215-0036

Don's Kohlhaft

Hospital or Attending Physician: 24 hours after deatl e Funeral Director: filled in by the within 2

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) MAR 1 8 2008

29b. Signature and title of certifier mo 29c. License number 3111

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Blud

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) March 17th 2008

2/23

30. Name and address person who completed cause of death (Item 23a) (Type, Print) Landrman

and manner stated.

Walth f+00

32. Registrar's Signature

	1 - For State Registrar  1. Decedent's Name (First, Middle,			artment of Health and I		g. No 2008	08751
nysician Medical	James R. K		sr.		Month March	13, 2008	3. Time of Death 3:15p M
xaminer neral ector	217-40-0586	e Road	e (In yrs. last birthday, 63 Yrs.	Baltimore  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.		4c. County of Death Baltimor Year) 9. Birth Cou 1945 Ter	place (State or Foreign
iffed at	Usual Residence of Decedent	imore	10c. City, Town or L	ocation Ltimore			10d. Inside City Limits 1 ☐ Yes 2 No
ust be notified	10e. Street and Number 7944 Lansdal	e Road		10f. Zip Code 21224	10	og. Citizen of What Cou	intry?
indical Examiner must be notified at letted by Funeral Director	3 XWidowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify: Whi	, etc.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Nanc. 01:00 PM 2000 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale HUSPITA Buttinder 1 Year It Under 24 Hrs. 8. Date of Birth (Month, Day, Year, April 17, Biltimura geriatric 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1 M 2 F Director 216-66-6116 1949 Germany Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be r 21014 6 Hunter Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: if item 27 is marked o Leonard Monroe M. Kirk Betty Louvic Sandberg မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard M. Kirk / Father 6 Hunter Drive, Bel Air, MD 21014 permit. Pages 1 an Department of Heal Important: if item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 3-18-08 Towson, Maryland 21. Signature of Funeral Service Licensee 23MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** prams /Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a ☐ Yes 2 No 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1☐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပ 1.2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2437 W West Belvedere Avenue Baltimore mo sern MD

State Registrar

31. Date filed (Month, Day, Year)

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene

1- Registrar

1- Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ELara 6:29 KEnt 2060 /Medical 4 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Geriatric HospitaL Baltimure Baltimire Ci Levindale (min) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/21/1915 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 □ M 2 X) F Director 213-28-3 92 CZECHÓSLOVÁKIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. BALTIMORE 1 ☐ Yes 2 No MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE, #622 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐**X**No Specify: WHITE Specify 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER LINEN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MANDL LITMAN HENRY JOLAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6542 SOUTHWIND CIRCLE, COLUMBIA, MD RUTH GOLDBERG / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 03/16/2008 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) f Funeral Service Licens 21. Sign ur 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) 62 Eneral /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical the attending place as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown been signed by te should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy certificate ha 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belue dere Avenue Baltimore mo 21215 2434 Sein West in MO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fb 9877 3-18-08 wt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Pay 2008 Year MARCH **JANETTE** KIBEL 14 6:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT & NURSING BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Monto) 6ay, Year) 10/26/1926 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 K F Director 415-58-2286 81 **POLAND** Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Directo BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 2414 SUGARCONE ROAD 21209 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No WHITE Completed by Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS RETAIL CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked DAVID STAPLER HANNAH **GERSNER** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN KIBEL SCHWARTZ / DAUGHTER 2414 SUGARCONE ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other plants of MEMORIAL PARK 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/16/2008 LARGO, FL 22. Name and Address of Facility 21. Signature of Funeral Service Licensee. SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2. No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1/22 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kaymond Mille 3/15/08 D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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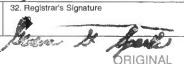
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Rustestown

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Rose Vaughan Lofgren 2008 6:45 p March 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14581 McClintock Drive <u>Glenwood</u> Howard If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Month, Day, Year) JUN 8 1918 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 X F 578-12-5542 89 West Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2X No Director MD Howard **Glenwood** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14581 McClintock Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must gonee. Funeral 21738 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith ျှ Laura Alice Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Letcher A. Lofgren - husband 14581 McClintock Drive, Glenwood, MD 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 3/17/2008 Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OBJUDINE PULMONAR Physician CHEONIL UFANI /Medical Due to (or as a consequence of): **Examiner** Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OFFENDENT 2 No 3 Probably 4 Unknown 1 TYes CEREBROVASCULM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MAR 18

egistrar's Signature

LOURT, SUITE 200 64ME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MANISHA

31. Date filed (Month, Day, Year)

BAHL, MD

32. Registrar's Signature

ORIGINAL

parts

BALTIMORE, MARYLAND 21220

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per dr., g8/7, 03/18/08dhb Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 11, 2008 **Physician** АМ MARY V. LAWRENCE 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/17/1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F VIRGINIA 225-46-5691 72 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at N/A BALTIMORE CITY 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4123 FAIRVIEW AVENUE 21216 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: Specify 3X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) K-MART CORPORATION RETAIL SALES CLERK 11THDepartment of Health and Mental Hygic Important: If Item 27 Is marked other Injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK RIDDICK EVERLINA EVERETT ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4123 FAIRVIEW AVENUE, BALTIMORE, MD 21216 LORENZO RIDDICK / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 3/15/08 WINDSOR MILL, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Sameral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Part Erner the disasse, or complications that caused the death of o not enter the mode of dying, such as cardiac or respiratory arrest, slyck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed ause (Final disease or condition resulting in death) **Physician** Maton ZUNIS /Medical Due to (or an a consequence of) **Examiner** 12hours Pneumonia Aspiration 5-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner rote Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medica! IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes > No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 22 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation I or Attend after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

(G)

awrence

DHMH 17 Rev 1/2001

Registrar

MATHEN R BAYOWIN LIRFATER BATTIMORE PATOLICAL LEWIFIR, 1565 NOIGH CHARLES STREET, BATTIMORE 21204

MEDICALDOGOR

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

18

2008

D0065708

March 11 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene 23a, Pt11, 23d, 25 per me, 8877, 03/14/08dhb Reg. Not. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:00 PM M February 18, 2008 Adolfo L. Lopez /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Montgomery Derwood Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Date of Birth (Month, Day, **Funeral** Days Year Months Hours Min 1 M M 2 □ F 52 N/A 04/01/1955 Argentina Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 28a-f show at 1 □Yes 2 No notified Director MD Gaithersburg Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Pe ö 20882-Argentina 7010 Damascus Rd. or items 23a must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 M Married 1⊠Yes 2□No Specify: Argentina Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Upholstery filed within 7 Hygiene. College (1-4or 5+) than Elementary/Secondary (0-12) Self Employed 9 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Sosa Ramon Lopez ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Delia Lucero de Lopez/Wife 7010 Damascus Rd. Gaithersburg, MD 20882-Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb 25 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland 2008 Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service NO0382 any Rapp Funeral & Cremation Serving 933 Gist Ave. Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PIR /Medical Due to (or as a consequence of): Examiner FUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trans and Due to (or as a consequence of) attending physician Cerebral Infarction with Complications Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day for L Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Diabetes Mellitus omed? 2 Mo 2□No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -2 No 1 MInpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide

Box 68760, P.0.

death with the

72 hours after

3altimore, Maryland 21215-0036

Division or Vital Records,

or Attending 24 hours after death Funeral Director: Hospital the within 2

> State Registrar

and manner stated.

29c. License number 00065024

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and

9901 MEDICAL CENTER DR. KOCKVILLE MD 20850

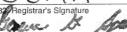
31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature

(Check only one)

7 MAR 1 2008



Medical

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year JACK 0423 AM 14 2008 LAMBERT MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death USIVERSITY SP BALTIMONE MARYLAND MEDIAL CENTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 212–26–7633 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 1 XM 2 ☐ F Maryland 79 1192 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 TYes 2 XNo Delaware Sussex Dagsboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19939 U.S.A. 31221 Dogwood Acres Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 12 years Tin Mill 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Burbett James T. Lambert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 279 Winterberry Lane, Westminster, Maryland 21157 Georgia Allen Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 18, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYGLOBUASTIC LEUKBMIK ACUTE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Tyes 2M No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **N**No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical **Examiner** 

and

Physician

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

"natural", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once.

Baltimore, Maryland 21215-0036

with the Maryland

Examiner Physician/Medical þ Completed Be Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed signed by the attending physician has After after death. in by t within 24 hours a

To the Funeral C Hospital the

Division or Vital Records, P.O. Box 68760,

1

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

27. Manper of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

NORMAN

5 Pending investigation

6 Could not be determined



28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ST

P21136

BAUTIMORE

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARRIL

MO

29d. Date signed (Month, Day, Year)

21201

2008

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day MINTON Year **Physician** AINE ANNE 6.57AM MARCH 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** Days Months 1 □ M 2 🕅 F Maryland Director 214-24-9650 Sep. 7, 1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dicaf Examiner must be notified at Anne Arundel 1 ☐ Yes 2 No Director Linthicum 10e. Street and Number 613 Forest View Road 10f. Zip Code 10g. Citizen of What Country? 21090 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: ≥ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Transportation 12 Bookkeeper Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last)
Joseph Mazza 18. Mother's Name (First, Middle, Maiden Surname) Anna Lillian Carnaggio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith J. Minton - Son 1640 East Lombard Street, Baltimore, MD 21231 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 R 3 ☐Removal from State 3-19-2008 Elkrisge, MD Memorial Park
22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammons Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOTENSION 1 Week /Medical Due to (or as a consequence of): Examiner FAILURE 1 week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and Due to (or as a consequence of): physician a s the burial-t Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 MInpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR Mamatha Phabhakar, 3001; S. Hanover Street, Baltimore - MD-21225 32, Registrar's Signature

M.D.

2008

porte

29c. License number

RES 001

29d. Date signed (Month, Day, Year)

Maych 17 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3:50^{P™} James D. M. Muldowney March 11 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford Edgewood Nichols Senior Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1**∑**M 2□ F 170-30-6004 Pennsylvania 68 1939 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9432 Joppa Pond Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 1957— Year or Dates: 1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Police Officer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew Muldowney Josephine Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mate

Physician /Medica **Examine** 

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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MD.

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

within 24 hours after death. To the Funeral Director completely filled n by the Certifica

		di:
	al Examiner	Se if a ca Ca tha res
	ysician/Medic	IF 23
	ompleted by Phys	Par
	n: To Be Con	25.
	ation:	27.

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

Stephanie 31. Date filed (Month, Day, Year)

6 ☐ Could not be

hance

MAR 18

Barbara A. Muldov	wney/ Wife	9432 Jo	ppa Pond	Rd.Baltimome,	MD. 2123	4
20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State Gar	lace of Disposition (Na emetery crematery of Cens of F Emetery	aith 0	3/15/08 Ro	s. Location - City or sedale, M	D.
21. Signature of Funeral Service Lice	Valls	Evans 8800	nd Address of Facility Funeral Harford	Chapel & Crena Rd. Parkville	tion Serv MD. 21234	ices
2. a. Pa il. Entertile disease, or com sh ck, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the mo	de of dying, such as	cardiac or respiratory arrest		Approximate Interval Between Onset and Death
Immedifite Cause (Final diseasi or condition resulting in death)	a. UFOSEPS Due to (or as a consequence)  Alzher me	uence of):	use			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  Due to (or as a consequence)	uence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 □Ectopic p			23d. Date of de Month	livery Day Year
Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	cause given in Part 1.	1		o the cause of death? robably 4 ⊠Unknown
				24a. Was an autopsy performe 1∐ Yes 2∑	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?			26. Place	of Death (Check only one)		
examiner/ 1 ☐ Yes 2 ② No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □ D	OA Other: 4 Nu	rsing Home 5 Residenc	e 6 MOther (Spe	ecity) hospice
27. Manner of Death  1 Natural 5 Pending investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ I	28d. Describe how		

Macertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 10043909

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)
March 13, 2008

Registrar

1021

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephanie Linder MD 902 Averill Rd Joppa, MD 21085

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3: Time of Death 16, 2008 7:06 AM March Glendora M. Martin 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Timonium Stella Maris Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 21, 1921 Birthplace (State or Foreign Country) Days Months Hours Min. 004-22-9223 1 □ M 2 1 1 Maine Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Baltimore MD. 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8503 David Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abbie Nichols Harry Handy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Buccheri/Daughter 8503 David Avenue Baltimore, MD. 21234 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Dulaney Valley 1 Burial 2 □ Cremation 3 □ Removal from State Timon im, MD. 03/19/08 4 Donation 5 Other (Specify) Memoriál Gardens 21. Sign Ture of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscieronic Cardio varcular disease or condition resulting in death) Due to (or as a consequence of): Securifically list for differential if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23a or 28a-f show ner must be notified at

Examiner

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Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the M

Item 27 is other tra

permit. Pages 1
Department of H
Important: If ite
any injury or ot

Director

Funeral

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Completed

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the Maryland

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

burial-tra physician s the burial attending ph signed by the a certificate ha uneral director, this After al Director:

The law requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records.

the Hospital or Attending Physiclan;

24 hours a filled

within 24 hou To the Fune completely fi

Examine Physician/Medical Completed by Be ဥ 27. Manner of Death Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Ves 2 No 9 Unknown

25. Was case referred to medical 1 Yes 2 No

k ■ Natural

2 Accident

3 Suicide

29a. Certifier

one)

4 Homicide

(Check only

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔲 Inpatient

2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

Ruad Weilminster

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

9,14 due

State Registrar

Medical

18

08-01885 Zion Levi Metz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

on Le	vi Metz		1- For State Registrar	State	of Maryland		tment of <i>ficate of l</i>		d Menta	al Hygien	<b>e</b> Reg. I	No. 200	8 08760
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edica	al Exami	ner	Zion Lev:		e street and number	·)	1 41	o. City, Town, o	Location of		ch 6, 200	08 4c. County of Deat	
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	Funeral		5. Social Security Nu	umber 6. Se	2x 7. A	ge (In yrs. las	t birthday)	If Under 1 Yes			te of Birth(N	MM/DD/YYYY) 9. Bi	
[	Director		212-27-48	824 1🗓	M 2 F	19	Yrs.	Months Day	s Hours	Min. May	1, 1,	1988 ^C	ountryMaryland
	ay.	F	Usual Residence of I	Decedent 10b. County		10c. City. T	own or Location	en					10d. Inside City Limits
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	arylan 8a-f sl at onc	Director	10e. Street and Num				11011 110	10f. Zip Code			10g.	Citizen of What Co	
	the M		10646 016	d Nationa	al Pike				21774			USA	
	be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 X Never Marries	ed 2 Married	12. Was Deceder			Decedent of H				14. Race - Ame White, etc.	rican Indian, Black,
	er deal		3 Widowed		1 Yes	2 X No	1 1	Yes 2 x N	snecify:			Specify:	1
	ours aft itural' amine	Completed by	15. Decedent's Edu		If Yes, Give Year or Dates: nly highest grade co	mpleted) 1	6a. Decedent'	s Usual Occupa	ation (Give ki		ie 16	6b. Kind of Business	vhite /Industry
9	an "na cal Ex	ete	Elementary/Secon	ndary (0-12)	College (1-4 or	5+)	during mo	st of working lif	e. DO NOT u	ise retired)			
003	within giene. her tha	E E	12 17. Father's Name (F	First Middle Last	0		server	<u> </u>	18 Mother's	Name (First I	Middle Mai	food sea	vice
215-	uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Be C	Douglas		1			,		ron Ros	,	•	
MD 21215-0036	교육 등 하	2	19a. Informant's Nar		ype, Print )		19b. Mailing	Address (Stre	et and Numb	per or Rurat Ro	ute Numbe	er, City or Town, Sta	te, Zip Code)
Σ	ss I and 2 should of Health and Me If item 27 is ma her traumatic ev		Douglas M		ner	Laon Di		01d Na		1 Pike Date		Market, MT	
Baltimore,	permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic				Removal from S		ematory or other		sinetery,	Date		LOC, LOCATION - Only C	Town, State
ţi.	it. Pag rtment prtant: y or o		4 Donation 5	X Other Specify	in state		22 N:	ame and Addre	s of Facility				
Ba	Depa Impe		21. Signature of Fun	maid S.	Wady, Di	tector	Sta	te Anat	omy Bo	oard 65 21201	5 W.	Baltimore	Street
	nysician	-	23a, Part I. Enter the	e disease, or comp	plications that cause	ed the death. I	Do not enter th	e mode of dying	, such as ca	rdiac or respira	atory arrest	, shock, or heart	Approximate Interval Between Onset and
	Medical xaminer	ìΥ	Immediate Cause (Final disease or condition resulting in death)  a. Hanging  Due to (or as a consequence of):									Death	
		ner	Sequentially list con if any, leading to im- cause. Enter Under	mediate	Due to (or as a con	sequence of):							
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68760,	tificate ng phy as the		IF FEMALE: 23b. Was decedent p past 12 months?	pregnant in the	23c. If yes, outc	ome of pregna	-	al death 3	Ectopic	pregnancy		Month	Day Year
Box 6	The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	sician/N	1 Yes 2 N			at time of dea	th 5 Oth	ner (Specify)					
Ö.	the de by the sched f	Phy	Part II. Other signif		9 Unknown	ath but not res	sulting in the u	nderlying cause	given in Par	rt I. 23	e. Did toba	acco use contribute	to the cause of death?
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tal F		Be C	25. Was case referre		Hospital:		•		Other	Check only on	-		
Ž	Attending Physicians r death. ector: After this certifi by the funeral director.	유		2 No	pu		ER/Outpatient 28b. Time of Ir		jury at Work	Nursing Home		esidence 6 Oth	ner:
		ion:	1 Natural	5 Pending	28a. Date of Ir FOUND: Day		FOUND:		Yes 2	Subje	ct hange		
Division	r Atte ter des irecto in by th	fica	2 Accident 3 ✓ Suicide	Investigat  6 Could not	28e Place of		1940 hrs ne, farm, stree	et, factory, office	building, etc				Rural Route Number, City
ä	ours af	Certification:	4 Homicide	determine		ingle Fami	ily			10646	Old Nat'l	ite) Pike, New Marke	t, MD
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 (Check only one)	Certifying Physic Medical Examine	ian: To the best of	my knowledge amination an	e, death occuri d/or investigati	red at the time,	date and pla	ice, and due to	the cause( ne, date ar	(s) and manner as si nd place, and due to	ated. the cause(s)
	To the To the Comp	Medical	29b. Signature and		and mariner state	d	-2.34		nse number			29d. Date signed (A	
		_	-		Us			0.0	c.M.E.			March 7, 2008	
			30. Name and addre										
			David Fowle		ef Medical Exa			reet, Baltim	ore, MD 2	21201			
	S Regis		31. Date filed (Mont	th, Day, Year) 1R 1 8 20	08 32 Regist	rar's Signatur	e //24				_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. **Physician** Katherine Floyd Messenger /Medical Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death Examiner 8. Date of Birth (Month, Day, August 7 If I Inder Birthplace (State or Foreign Country) Social Security Number 6. Sex . Age (In V **Funeral** 1□M 2□F Months Days Hours Min 95 216 01 3734 Baltimore Co., Md. Director 1912 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 10103 Bird River Road 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 6 1 ☐ Yes 2 ☑ No Specify: Specify. Completed by 3 X Widowed 4 ☐ Divorced "natural", White. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) than . Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M NAHomemaker Housekeeping-Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Smith ဂ Augusta Magsamen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward E Messenger 1104 Mill Creek Road Fallston, Marvland 21047 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gdns. March 19 2008 Bel Air, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7401. Belair Road Baltimore, Maryland 21236 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Lassahn Funeral Home Inc 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of) Examiner law requires that the death certificate be executed physician and the burial-transi and Due to (or as a consequence of) Box 68760 Physician/Medical attending p for use as use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. cate has been signed by the a page 2 should be detached 9 Unknown 9 ☐ Unknowe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Tes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performed 1∐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director: .

completely filled in by the f 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of egrtifier 29d. Date signed (Month, Day, Year)

State Registrar 30 Name and

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Frank

Cedric Fisher

idress of person who completed

8 2008

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31. Date filed (Month, Day, Year)

MAR 1

3/15/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15 2008 Lillian Α. Mathias March РМ 6:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 108 Broadway Anne Arundel Pasadena 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 07 1934 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☑ M 2 □ F Months Hours 219-26-2551 73 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Broadway 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: <u>ک</u> Specify: 3 ☐Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H iant: If item 27 Is marked oth Be Clifford Martin Ida Pramschaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other training once. Brenda Boyles 7639 Beach Dr. Pasadena, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Md. Veterans Cem. 3/20/08 4 □ Donation 5 □ Other (Speck Crownsville, Md. 22. Name and Address of Facility 3111 Mountain Rd, Pasadena, Md. 21. Signature of Funeral Service Lice Stallings Funeral Home PA 21122 23a. Part1. Enter the cease, or complications that shock, or heart fail te. List only one calls on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequ **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: igned by the attendin be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4□Pregnant at time of death □Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier light of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Media at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year 29b. Signature and tit ense number 30. Name and address of person

State Registrar

31. Date filed (Month, Day, Year)

MAR 18

DHMH 17 Rev 1/2001

egistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** Mickens 7,2008 March 1405 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 4, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 59 Yrs. 577-74-4419 Bishopville SC **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1√□Yes 2 □ No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12608 Gladys Retreat Court 20720 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator BoJo's Trucking Co. Seventh None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Mickens Lula Brisbon ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 396 River Ridge Court, Laurel MD 20724 Calvin Mickens/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once, 1 DBurial 2 □ Cremation 3 □ Removal from State Ft Lincoln Cemetery 14,2008 4 □ Domation 5 Other (Specify) Brentwood, MD 22. Name and Address of Facility Robert G. Mason Funeral Home Inc Funeral Service 21. Sign ture 1661 Good Hope Rd SE, Washington DC 20020 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has birector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 ☐ Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division or Vital Records, P.O. Box 68760, s after death. within 24 hours a

To the Funeral I

completely filled filled

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4467 OLD Branch AVE \$201 Temple Hills, MD 20748 diaeemD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 8 2008

Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per registration 03/14/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ac. County of Death 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner raltimora MIA 1052,1701 lary Land 5. Social Security Number ast birthday) If Under 1 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1 M 2 KF Months Days Hours 215-18-7532 Usual Residence of Decedent Director LAND 10d. Inside City Limits 10b. County 10c. City, Town or Location iral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45A 14. Race - Américan Indian, Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mendal Hyglene. Department of Health and Mendal Hyglene. Thattur Mondrant: If flem 27 is marked other than "natur any injury or other traumatic event, the Medical in any injury or other traumatic event, the Medical in the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ို 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 02-21-08 BALTIHORE, 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RIPPLE HATTY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last VALUED 31 MEDICAL Examiner The law requires that the death certificate be executed sician and bunial-trans Due to (or as a consequence of) Box 68760; physician s the buria Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month 5 Other (specify) P.O. ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 ☐ No 1∏Yes or Vital 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 1 Tres 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 El Natural 5 ☐ Pending investigation 02/04/2008 death. 2 Accident Unknown^M 1 ☐ Yes 2 🙀 No Subject fell. within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 501 Dolphin Street Apt 1115, Baltimore, Md 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address in person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene
1- State of Maryland / Department of Health and Mental Hygiene
Registrar

State of Maryland / Department of Health and Mental Hygiene
Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 45 PM 2008 Fountain Kenneth Manear /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 □ F 87 235-16-0041 02/03/1921 West Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Md. Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 516 North Marlyn Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify White þ Specify: 3 Widowed 4 Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly Injury or other traumatic event, the M. ct. al 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 12 Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fountain Benjamin Manear Okel Edgell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olive Manear - wife 1813 Old Eastern Ave., Apt. 230, Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Conation 5 □ Other (Specify) Gardens of Faith 03/11/2008 Baltimore, MD 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Sign June of Funeral Service 1407 Old Eastern Avenue, Essex, MD 21221 chunc 23d. Part1. Enter the disease, or complications the coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** Due to (or a a consequence of): disease or condition resulting in death) /Medical **Examiner** NOXIE Sequentially list conditions Examiner il any leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit Hypertensive Atherosclerotic Cardiovascular and Due to (or as a consequence of): Disease physician Physician/Medical use as the attending IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy ō Month Day in the past 12 months? Year 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 - 100 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 2 ER/Outpatient 3 DOA P To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Res 0000 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) nullain 4000 FRANKLIN Square Balto in D 21237 ): nother DR 31. Date filed (Month, Day, Year) MAR 1 7 2008 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MAE MORELOCK SARAH MARCH 16, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPICE DOVE HOUSE WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🖸 F 218-03-7060 88 Director 6/28/1919 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD CARROLL WESTMINSTER 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 210 E. 21157 GREEN ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🗓 No þ Specify: 3 ☐ Widowed 4 N Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS 11 SEWING FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HUMBERT MARTHA FLICKINGER JOHN W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod2) 1 1 5 8 19a. Informant's Name/Relationship (Type. Print) DAVID R. MORGRET -NEPHEW 3916 LITTLESTOWN PIKE, WESTMINSTER, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3/17/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) WINFIELD, MD SOUTH CARROLL CREMATORY 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) Examiner done Sequentially list conditions, if any, leading to immediate each. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Due to (or as a consequence of) physician a Box 68760. Physician/Medical as 1 attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown led by the a Ö 9□Unknowr ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been signed 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate Division or Vital 1□ Yes 2 No Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}X$ Other (Specify) HOSPICE1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After or Attending Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Within 24 hours are
To the Funeral Dir Hospital

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DHMH 17 Rev 1/2001

State

Registrar

and title of certifier

address of person who

29a. Certifier (Check only one) 29b. Signatura

30. Name a

31. Date filed

eted cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

manderty

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year McComb Sylvia Kay 14, March 2008 3:12 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Center Timonium Baltimore Co. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Year) Months Days Hours 1□M 2🔼 F 62 Yrs Director Jan. 30,1946 Maryland 212-46-5819 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Maryland 1 XYes 2 No N/A Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States 1300 Broening Hwy. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 P No þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) *Homemaker* 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If them 27 is marked or any injury or other traumatic eve once. Alvis C. Winn Pauline Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher McComb Sr. - Son 1910 Mars Run Road Essex MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hill Cemetery 03-17-2008 | Middle River Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Diala-Ruck Funeral Tiome of Dundalk Inc. 7922 Wise Avenue Dundalk MD. 21222 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) ean Physician Conyestive /Medical Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a nunsequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2**.** No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Stother (Specify) House 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

**Examiner** Fo the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, signed by the a has e 2 s this After this after death within 24 hours after To the Funeral Di completely filled in

with the Maryland r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

"natural", or items 23a or

other than "natu vent, the Medical

attending physician a for use as the burialcertificate ha director, Certification: To

28c. Injury at Work? 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certific 29c. License number

State Registrar

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) -tmoup 19, P 2008 32 Aggistrar's Signature 19, Pidre 31. Date filed (Month, Day, Year) MAR 18

29d. Date signed (Month, Day, Year)

Road Westminister MD21157

08-02127

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Henry Niemann 2008 087 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 16, 2008 1125 hrs Me≺ical Examiner Henry Otto Niemann 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** St. Agnes Hospital g. Birtholace (State or Foreign Pennsy Lvania If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months Country) Director 1 X M 2 F 1907 127-07-2627 100 Aug 14, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location my. 10a, State 10b. County 1 Yes 2 X No 28a-f show s 23a or 28a-f shov e notified at once. Maryland Baltimore Reisterstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 USA 901 Timber Run Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. , or items r must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married hours after death Yes 2X No specify: White Divorced If Yes, Give Year Yes 2X No specify: 3 X Widowed narked other than "natural", event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) rmit. Pages I and 2 should be filed within 72 I partment of Health and Mental Hygiene. portant: If item 27 is marked other than "1 ury or other traumatic event, the Medical E ury or other traumatic event, Building | 21215-0036 Architect Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Belanska Be Henry Niemann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Q. 901 Timber Run Road Reisterstown, MD 21136 Robert A. Niemann, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 22 Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryl
Me death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart
Injury 03/18/08 Baltimore, Maryland Donation 5 Other Specify: 21. Signature of Funeral Service Licensee and Thomas Gregor\ Approximate Interval 23a. Part I. Enter the disease, or complications that aused to failure. List only one cause on each line. Neck Physician Medical Between Onset and failure. List only one cause on each line. Death a Atheroselerotic Cardiovascular-Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit кесогds, P.O. Box 68760, К 23a,27,28a-f, perME, g887 1/23/09 TT Physician/Medical AMENDED UNPENDED attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Day Year 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? e has been signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown ğ leted 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Compl certificate has ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be Other examiner? Hospital: 1 Inpatient 2 🖊 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: DOA 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natoral 1 Yes 2 X No Pending 3/16/08 10:00 am 28f. Location (Street and Number or Rural Route Number, City or Jown, State) 3320 Benson Ave Baltimore, MD 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify) Nursing Home 6 Could not be 3 Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number March 17, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

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Registra

Carol Allan, MD 31. Date filed (Month, Day, Year) **State** 

Assistant Medical Examiner

OCME

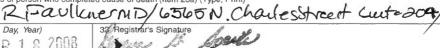
111 Penn Street, Baltimore, MD 21201

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician March 15^{ay} 2008 3:20 P M Rose Najarian /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 ☐ XF 86 155-01-2441 Director New Jersev 1-08-1921 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notifled at 1 ☐Yes 2 X No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2141 Suburban Greens Drive 21093 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Secretary Police Department 7 Is marked other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sophie Vasilian Harry Najarian 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau 2141 Suburban Greens Drive, Timonium, MD John Guillott / Brother-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03-19-2008 Timonium, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Lawria 1050 York Rd., Towson, MD 21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Discose Arterioscled **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical the as attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9☐Unknown 9 ☐ Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s performed? autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No 1 ☐ Yes 2 XER/Outpatient 3 □ DOA ပ 1 🔲 Inpatient 27. Manner of D ath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: , d in by the f 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) MAR 1 8

29b. Signature and title of certifier



Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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Registrar

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Physici	an/	Decedent's Name (First, Middle,Last)					2. Date of Death Month March 16, 1		3. Time of Death 1457 hrs
/ledical Exami • े∝	iner	Mary Virginia Owing  4a. Facility Name (If not institution, give street and nun		4h City	Town, or Loca	tion of Death	March 16,	2008 4c. County of E	
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Funeral		5. Social Security Number 6. Sex	. Age (In yrs. last bi			Under 24Hrs.	8. Date of Birtl	h (MM/DD/YYYY) S	Birthplace (State or Foreign Country)
Director		212-20-3493 1 M 2X F	83	Yrs. Mont	hs Days H	Hours Min.	09/28/	1924	MD
y		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	o or Location					10d. Inside City Limits
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Maryland 28a-f show d at once.	ctor	MD   Carroll  10e. Street and Number		Hampstea 10f. Zi	p Code		T10	g. Citizen of What	
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hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.		11. Marital Status 12. Was Dece	dent Ever in U.S.	13. Was Deced	lent of Hispani	c Origin? ( Spe			American Indian, Black,
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s after ral",	ð.	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	144.0		2 X No sp		anti dana	Specify: 16b. Kind of Busin	White
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)  College (1-		. Decedent's Usua during most of we	orking life. DO	NOT use retire	ed)	TOD. NING OF BUSIN	less/industry
336 thun 7: ne. than	nple	12	, ,	Secret	ary			Baltimor	e Co. Schools
215-0036 be filed within 72 ntal Hygiene. rked other than "		17. Father's Name (First, Middle, Last)				lother's Name	(First, Middle, M	laiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Robert F. Brown	- 12	Ol. M. Dr. Addes	10		aret Ca		0 7. 0. ( )
MD 21 rd 2 should alth and Me m 27 is man	ř	19a. Informant's Name/Relationship (Type, Print)  Gary E. Owings So	14.		,			ther, City or Town, MD 2115	
- 95 E E		20a. Method of Disposition	20b. Place	of Disposition (Na	ame of cemete		Date	20c. Location - Ci	ity or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If itel		1 X Burial 2 Cremation 3 Removal fro	ii State	atory or other place green Men		1 2	/24/08	Finkah	ourg, MD
Baltimo permit. Page Department of Important: injury or oth	Ì	4 Donation 5 Other Specify: 21. Sign for of Funeral Service Licensee			d Address of F				stown Road
E P P E		Kanst Un	Ý	Eline	Funera	1 Home	Reist	terstown,	MD 21136
Physician /Medical		a. art I. Enter the disease, or complications that ca f illure. List only one cause on each line.		not enter the mode	of dying, such	n as cardiac or	respiratory arre	est, shock, or heart	Between Onset and
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iox 68760, eath certificate be execut a attending physician and for use as the burial - trai	Physician/Medical Examiner	UNPENDED AMENDED							
6876 certificate nding phy se as the b	Ž	23b. Was decedent pregnant in the	utcome of pregnance	y 2 Fetal deat	n 3 E	Ectopic pregna	ncy	23d. Date of de Month	elivery Day Year
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ing Pl	اڃَا	27. Manner of Death 28a. Date (Month.	of Injury 28b	Time of Injury	28c. Injury at			how injury occurred auto to auto c	
Sion ttend death. ctor: y the f	atio	2 Accident Investigation		12 hrs		2 <b>V</b> No			
Division of Vital Rec pital or Attending Physician: The ours after death. Peral Director: After this certificate filled in by the funeral director, page	Certification:	Suicide Could not be	of Injury - At home, Major Road / I		ry, office build	ing, etc.	28f. Location (\$ or Town, S MD Rt 482 @	Street and Number State)	or Rural Route Number, City Drive, Hamstead , MD
lospit 4 hour uners		29a. Certifier			he time, date a				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On the basis of and manner st	f examination and/or	r investigation, in r	ny opinion, de	ath occurred a	t the time, date	and place, and due	e to the cause(s)
F . ¥ E 0	Me	29b. Signature and title of certifier	alou.	2	9c. License nu	ımber		29d. Date signed	(Month, Day, Year)
		Yamet Con the 11. min			O.C.M.E	Ξ.		March 17, 20	008
10		30. Name and address of person who completed caus			in Stroct D	altimore *	MD 21201		
	tota	31 Date filed (Month Day Year) 18/ Re	Medical Examin gistrar's Signature	4	m Sueet, B	saltimore, N	- L L L L L L L L L L L L L L L L L L L		
Regis	tate trar	MAR 1 8 2008	15 d SS 1	Gooder					

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MARCH **Physician** 2008 7:30A M Albert Louis Ousborne, Sr. /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10-10-1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F 90 705-10-9076 Yrs. Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MDBaltimore Towson 1 ☐Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA 45 Theo Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Asst. to General Super permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Ship Repair ntendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Evelyn Beck Louis Ousborne ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 St. Francis Rd., Towson, MD 21286 Albert L. Ousborne, Jr./Son altimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03-20-2008 Parkwood Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21204 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-transi C DE Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical The law requires that the death certificate 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 10 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in my opinion, death as a stated with the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert D24034 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 8 2008 1150 Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar	Otate of Me	ii y iai ia	Cer	tificate of		wieman riy	Reg. No	2008	08776
7	Physicia	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Time of Death
166	/Medic		EDWARD							14	200	42
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, o		th		County of Dea	
	***************************************		5. Social Security Number 6.5	AN HOSPI	TAL (In yrs. las	t birthdav)	ISALTI If Under 1 Year	MORE If Under 24 Hrs	8. Date of Bir	th	9. Bir	thplace (State or Foreign
	Funeral Director		,	1 <b>≾</b> M 2□F	83	Yrs.	Months Days	Hours Min	April 14	y, Year)	Co	ryland
	yland now at		10a. State 10b. County		10c. City, T	Town or Lo	cation					10d. Inside City Limits
	a-f sh	ctor	Maryland N/A	4		Bo	x1+im one					1 X Yes 2 □ No
	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	al Director	10e. Street and Number	Air Road			10f. Zip Code	206			en of What Co	ountry?
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	)- 1	<ol> <li>Race - Ame Black, Whi</li> </ol>	
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12	filed withir Hygiene. ther than	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+)	-	Brick M			t	Mason	مدم
9	filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last	")				18. Mother's Na	me (First, Middle,	, Maiden :	Surname)	<u> </u>
/an	should be filed within and Mental Hygiene. s marked other than umatic event, the M	To B	William	Purvis				M	able	(,	in Kno	wnJ
Maryland	2 short and N is ma		19a. Informant's Name/Relationship	(Type. Print)	i		ng Address (Street					
	12 mg		Tyrone Puruis 1	son	John Blas	10 N	orth Wo	olfe Stre	ret Ba	utim	ere, M	D 21231
Ö	iges 1 and of the sit of the sit if item or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cem	netery, crer	natory or otner pia	ce) ;				
Baltimore,	permit. Pages 1 Department of F Important: If Ite any injury or ot		4 Donation 5 ☐ Other (Special Signature of Funeral Service Lice	·	Anad	torny (-	Name and Addre	stry Marc	h18,2008	Hai	nover	MD
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			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each lin	the death.			-		rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Meta	bolic	er	ncephal	opathy				
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50,	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequer	nce of):						
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	certific Iding pl	/Me	IF FEMALE:	23c. If yes, outcome	pf pregnanc	:y		-			23d. Date of de	livery
Box	death cer attendin d for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐Pregnant at			Ectopic pregnanc Other <i>(specify)</i>	у			Month	Day Year
P.O.	at the de by the a	hys	9 Unknown	9□Unknown								
Records, F	s th: gned e de	by	Part II. Other significant conditions	contributing to death bu	ut not resultii	ng in the ui	nderlying cause giv	ven in Part I.	23e. Did 1		,	to the cause of death? Probably 4 □Unknown
000	aw require s been sig 2 should b	Completed							24a. Was		24b. Were a	utopsy findings available completion of cause of
Ä		mo:								ormed? 2 □ No	death? 1 ☐ Ye	
Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				lau		eath (Check only	one)		
or/	Physician: r this certificaral director, I	은	1 Yes 2 No	Hospital: 1 Impatie		R/Outpatier 8b. Time of	ot 3 DOA Oth	4 🗆 Nursing	Home 5 Resi			ecify)
no	ding T. After fune	ion:	27. Manner of Death  1	(Month, Day	Year)	Injury	Wo	rk?  Yes 2∐No	28d. Describe	now injur	y occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 200 Place of init	Iry - At home c. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location ( City or To	Street and wn, State	d Number or F )	Rural Route Number,
ш	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination	edge, deatl	h occurred at the ti vestigation, in my	me, date and pla	ce, and due to the curred at the time	cause(s)	and manner a	as stated. ue to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene	0	
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For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Howard Peterson March 1, 2008 12:49 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1911 Frederick Street Cumberland Allegany If Under 1 Year | ff Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 ☐ F Yrs 79 Director 213-24-6958 Usual Residence of Decedent Pennsylvania Feb 21, 1929 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Iteme 23a or 28a-f show f Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28a-1 shov other treumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No MD **Allegany** Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 1911 Frederick Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married XYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 150-52 1 ☐ Yes 2X No Specify: white Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 mechanical engineer tire company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thelma Ruth Ulsh Roy Ray Peterson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Frederick Street Cumberland, MD 21502 Rosemary Peterson/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Dale 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: if Ite eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** ONGESTIVE /Medical Due to (or as a consequence of): Examiner emic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: use 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. P signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1☐ Yes 2 1 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 2 1 Yes 2 No 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of-Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; Division 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. ÷ 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 2 MARCH 11, 2008 30 Name and address of person who co eted cause of death (Item 23a) (Type, Print) WAOGNER MMBERLAND MP 21502 WASSIT RD JARI 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Jak Sul MAR 18 Registrar

Registrar

State

29b. Signature and title of certifie

ADEWUNMI

31. Date filed (Month, Day, Year) MAR 1 8 2008

AS CURLINAZ, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ULUYEMISI

29c. License number

D 594018

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** March 14, Stella 11:43 pm[™] Panageotou /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Towson Baltimore Towson 5. Social Securify Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Yea Jan. 1, 1 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 213-70-3309 98 1910 Greece Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shorexaminer must be notified at 1 ☐Yes 2X No Baltimore Maryland Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 509 E. Joppa Road 21286 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X lo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic even Markakis Costas Chrisoula Sklavos 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trat once. 8614 Sherington Road Baltimore, Md. 21236 Gus G. Panageotou / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Murial 2 □ Cremation 3 □ Removal from State Greek Orthodox Cem. 3/19/08 Woodlawn, Maryland 4 Donation 5 Other (Specify) 21. Signature Funer Pervice Lic Hee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease, or constitutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List one cause on each line. Immediate Cause (Final Physician 3 week resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (also as or it jury) that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ signed d be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe this certificate 1□ Yes 2☑No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation within 24 hours after usure.

To the Funeral Orector Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 18 2008 MAR Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

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For State Registrar		Siate 0	ı ıvıaryıan		rtificate of			erre g. No.2 () () ()	08780
1. Decedent's Name (Fir	rst, Middle, La	st)					2. Date of Death Month	Day Year	3. Time of Death
Michael	A	nthony		Pighin	i		March	16, 2008	4:32 A M
4a. Facility Name (If not	institution, giv	e street and nur	nber)		4b. City, Town, o	or Location of Death		4c. County of Death	h
Baltimore W	lashing	ton Med	ical Ce	nter	Glen Bu			Anne Arui	
5. Social Security Number 181-52-451		Sex 1X M 2□F	7. Age (In yrs. 50		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2.	Year)   Cou	hplace (State or Foreign untry) PA
Usual Residence of Dec	cedent								10d Inside City Live
	b. County			ty, Town or Lo				l	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
MD Ar	nne Aru	ındel	G1	Len Bur					
10e. Street and Number					10f. Zip Code			g. Citizen of What Co	ountry?
403 Secret	t Bend				21061			U.S.A.	door to die
11. Marital Status		Armed Fo		l.S. 13.	Was Decedent of I	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White	
1 Never Married		1 ☐ Yes If Yes, Gi	2 <b>∕</b> ∑ No ve		1 ☐ Yes 2 No				hite
3 ☐ Widowed 4 🕅		Year or D	ates:	*				Оросину.	
15. (Specify o	Decedent's E	ducation ade completed)		1 (Give	edent's Usual Occu	during most of wor	king   1	16b. Kind of Business/	muustry
Elementary/Secondar	<del></del>	College (		life.	DO NOT use retire	9d)		East Coast	Concrete
12		4)		Lonci	rete Cutt	1			concrete
17. Father's Name (Firs		t)				18. Mother's Nam	ne <i>(First, Middle, M</i> Posev	осн очтате)	
Ernest Pigh	TIIT							0.4	7:- 0. / .
19a. Informant's Name	/Relationship	(Type. Print)		19b. Mail	ing Address (Stree	t and Number or Ru	ıral Route Number,	, City or Town, State, 2	∠ıp Code)
Ms. Jennife	er Pigh	ini /D	aughter			r's Court		rnie, MD 2	
20a. Method of Dispositi 1 ☐ Burial 2 🖺 Co 4 ☐ Donation 5 ☐	remation 3		State	cemetery, cre	position (Name of ematory or other pla ke Cremat	,	ch 20,	20c.Location - City or Stevensvill	
21. Signature of Funera	al Service Lice	ensee		2	22. Name and Addr	ress of Facility S	ingleton	Funeral & en Burnie,	Cremation
23a. Part1. Futer to d	disease, or con	mplications that	caused the dea						Approximate
snock, or mean ta	allure. List only	y one cause on	each line.	110	6	- Annua	/	1	Interval Between Onset and Death
Immediate Cause (Fina disease or condition resulting in death)	dl	a	las	ar V	202121	ajoy	Ulles	/	1000
resulting in death)		Due to	(or as a conse	quence of):	100	Tino	+175.	O Tit new	8 Some 11
Sequentially list conditi	ions,	b	(0	11/1	a le 5.	KAINE	112000	x VISUL	8-menth
Sequentially list conditi if any, leading to imme- cause. Enter Underlyin	ndiaté	Due to	(or as a conse	quen e of):	ц	TI			Por 1
that initiated events	iry 💮	C	6	ul	mana	til	00512		"Inda Po
resulting in death) Last	t	Due to	o (or as a conse	quence of):		9			
		d							
	- 1			-	in-	-			
IF FEMALE:	egnant		utcome pf pregr		Tectonia pro-	CV		23d. Date of de	
23b. Was decedent pre			birth 2 Fe		B∐Ectopic pregnan i ☐ Other <i>(specify)</i>	ioy .		Month	Day Year
in the past 12 mor									
		4□Preg 9□Unk							
in the past 12 mo 1 ☐ Yes 2 ☐ N	lo	9□Unki	nown	sulting in the	underlying cause ç	jiven in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
in the past 12 mo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lo	9□Unki	nown	sulting in the	underlying cause g	jiven in Part I.	23e. Did tot	1	to the cause of death? Probably 4 ☐Unknown
in the past 12 mo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lo	9□Unki	nown	sulting in the	underlying cause g	jiven in Part I.	1 □ Ye	es 2 No 3 P	Probably 4 Unknown
in the past 12 mo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lo	9□Unki	nown	sulting in the	underlying cause g	jiven in Part I.	1 ☐ Ye	es 2 No 3 F	Probably 4 Unknown autopsy findings available completion of cause of
in the past 12 mo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lo	9□Unki	nown	sulting in the	underlying cause g	jiven in Part I.	1 □ Ye  24a. Was a autops perfori	es 2 No 3 F	Probably 4 Unknown autopsy findings available completion of cause of
in the past 12 mo 1 □ Yes 2 □ N· 9 □ Unknown  Part II. Other signification  25. Was case referred	lo	9□ Unk	nown	sulting in the		26. Place of De	1 □ Ye  24a. Was a autops perfori	an 24b. Were a prior to death?	Probably 4 Unknown autopsy findings available completion of cause of
in the past 12 mor 1 □ Yes 2 □ Nor 9 □ Unknown Part II. Other significal	ant conditions	9☐ Unk	nown death but not re	ER/Outpati	ient 37 DOA	26. Place of De Other: 4  □ Nursing I	1   You 24a. Was a autops perform 1   Yes attn (Check only on Home 5   Reside	an 24b. Were a prior to death?	Probably 4 □Unknown autopsy findings available by completion of cause of the second second second second second second second second second second second second second second second second second second second second se

Examiner Examiner burial-tran attending physician for use as the buria Be Completed by Physician/Medical sate has been signed by the page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To

Director

Funeral

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Completed

Be

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Physician

/Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

and

IF FEMALE: 23b. Was deceder in the past 12 1 \( \superscript{Yes} \) 2 9 Unknow Part II. Other sign 25. Was case reference examiner? 27. Manner of Dea 1 ☑ Natural 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Obie Palmer 2008 0878 Certificate of Death 1- For State Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0648 hrs Medical Examiner March 7, 2008 OBIE PALMER WILLIAM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Ellicott City 8543 Pine Run Court If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** PENNSYLVANIA Months Days Hours APRIL 9, 1943 Director 64 177-32-0277 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No ELLICOT CITY HOWARD 28a-f show MD Examiner must be notified at once, death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21043 8543 PINE RUN COURT 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 X Married 2 X No Yes BLACK Yes 2 X No specify: Specify: permit. Pages I and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner.n f Yes, Give Yaar Divorced 3 Widowed ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 PRIVATE ENGINEER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELLA WILLIAMS Be OBIE PALMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ٥ 8543 PINE RUN COURT ELLICOT CITY, MD 21043 SHELIA PALMER/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 03-15-2008 | RIVERDALE, MD RIVERDALE CREMATORY 4 Donation 5 Other Specify 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED ed by the attending physician detached for use as the burial -UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 ✔ Probably 4 Unknown ģ Chronic Alcoholism Completed Records, 24a. Was an 24b. Were autopsy findings available certificate has been a prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA ER/Outpatient 3 Inpatient 2 After this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No 5 Pending -death. Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide

or Attending Physician: 24 within 24

DHMH 17 Rev 1/2001 **OCME 2006** 

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Pay) State Registrar

Homicide

29b. Signature and title of certifier

29a. Certifier (Check only

Medical

Registrar's Signatur BURE

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 7, 2008

determined

2008

		_	state amend #28c	Per Phy G877 3,	/18/08	rtificate of	Death	F	leg. No. 2 (	108	08782
	Physicia	an	1. Decedent's Name (First, Middle, Las	,				2. Date of Dea Month MARCH	_	2008	3. Time of Death
	/Medic Examin		JAMES C PE  4a. Facility Name (If not institution, give	RRY e street and number)		4b. City, Town, or	Location of Deatl		4c. County		9:20 P ^M
,	CAGIIIII	C1	2241 LINDEN AVEN			BALTII					
6	Funeral Director		216-16-2530	ex <b>X</b> M 2□ F 7. Age (In yrs. In 82	ast birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day AUGUST	Year) 3,1925	9. Birthp Coun	lace (State or Foreign try) MD
	land ow It	ł	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or L	ocation				1	0d. Inside City Limits
2	oeaun with the Maryland ms 23a or 28a-f show r must be notified at	tor	MD	BA	LTIMO	RE					¹X Yes 2 No
1	or 28e e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
1	atin wi		2241 LINDEN AVEN			1	217		US		
	be filed within 7.2 hours after bearth with the waryhat tall Hygiene. Id other than "natural", or ltems 23a or 28a-f show event, the Medical Examiner must be notifiled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.9 Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 No		pecify Yes or No- to Rican, etc.)	14. Rad Bla Specil	ce - Americ ck, White, fy: <b>BL</b>	
က်	natul 'natul dical	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind of B	Business/Ind	lustry
V	than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			d)		DEAT E	יכיד א ידיםי	COMPANY
7 0	med v Hygie Ither t	ပ္သ	17. Father's Name (First, Middle, Last,	<u>_</u>	CA	RPENTER	18. Mother's Nar	ne (First, Middle,			COMPANI
al		o Be	JOHN PERRY				EMMA	NEWMAN		ŕ	
wary	s I and 2 should f Health and Mei fem 27 is marke other traumatic	- 0	19a. Informant's Name/Relationship (	Type. Print)	19b. Mail	ing Address (Street	and Number or Ri	ural Route Numbe	r, City or Town	, State, Zip	Code)
≥ ;	and 2 ealth in 27 i		MYRA PERRY/DAUGH			1 LINDEN	AVE. AP		LTIMORE	, MD	21217
Hore	o		20a. Method of Disposition 1 → Burial 2 → Cremation 3 →	Removal from State	emetery, cre	osition (Name of ematory or other plac		Date	20c. Location	-	
	tmen tant: ijury		4 Donation 5 Dother (Specif	y) <b>K</b> ]		MORIAL PR			BALTIMO	-	
Balt	permit. Fag Department Important: any Injury c		21. Signature of Funeral Service Licer	a. Mandam	_   2	1701–31	-				S F.H., INC AND 21217
	5 A		23a. Part1 anter the disease, or comshoot, or heart failure. List only	plications that clused the death	n. Do not en						Approximate
P	hysician		Immediate Cause (Final	one cause on each line.	N 0	NState Co	inien to	lune			Interval Between Onset and Death
k.	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	NSTate (	arter jo	Corre			6 Munth
E	Examiner		Securation list overtices	b	pro	State (	concer				10 years
	s v ts	ine	Seque ritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ience of):						ŧ
	and and	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
09/90	ng physician and as the burial-transit			- d							
00	inicating bhy as the	fedical		u							
o D	sident: The law requires that the obtain betting ochtificate has been signed by the attending prector, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal		□Ectopic pregnancy	,			ate of delive	
5	the at	/sici	1 Yes 2 No	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify)		*		onth	Day Year
7	ad by detac	Ph	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	underlying cause giv	en in Part I.	23e. Did to	bacco use con		ne cause of death?
S C	ures sign	d by	COPD	,		, 0		1 <b>[X</b> [Y			ably 4 Unknown
Records,	s beer	Completed	Ų -					24a. Was a	an 24b.	Were auto	psy findings available
	ate has b	шо						autop perfor 1□ Yes	sy	prior to condeath?  1  Yes	mpletion of cause of
VIII	ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only of		10163	ZIZINO
2	this or	Lo.	1 Yes 2 No		ER/Outpatie		4 Li Nursing F	lome 5 A Resid	lence 6 □Ot	her (Specif	y)
DIVISION OF	After 1	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k?	28d. Describe h	ow injury occu	rred	
S	death ctor: y the	icat	2 Accident investigation 3 Suicide 6 Could not be		me, farm, st		Yes Zigiro	28f Location /S	Street and Num	her or Rum	il Route Number,
	after after Dire d in b	Certification:	4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	1)			City or Tow	n, State)	ber or rigio	i riodie radiiber,
	pospire hours unera ly fille	Salc	29a. Certifier 1X Certifying Pt	ysiclan: To the best of my know	wledge, dea	th occurred at the til	me, date and plac	e, and due to the	cause(s) and m	nanner as s	tated.
	in the nospital or Attending Fritysticans. To the Lat hours after death.  To the Lathours after death.  Completely filled in by the funeral director, I	edical	one) 2   Medical Exal	niner: On the basis of examinat and manner stated.	tion and/or i	nvestigation, in my o	ppinion, death occ	urred at the time,	date and place	, and due to	o the cause(s)
ļ	To To	Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
	1	}	ranva	MO		D-0	026254		Marc	h 17,	20.8
	H		30. Name and address of person who	and manner stated.  Completed cause of death (Item  Unim We  32 Registrar's Signa	23a) (Type	cl itosizi	tal	Baltin	na MD	2,21	ð
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	prite V	2200	- 4	, -( . , 1)			<u> </u>
	310			2.5.4	3m 19.00	100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to					

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. 32. Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

03-13-2008

GLESNE STREET BACTIMORE MP 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** CTHIAM 2008 Edward LeRoy Rottman, Jr. /Medical 4a. Facility Name (If not institution, give street and nur, 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Numb Date of Birth (Month, Day, YApr. 4, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** . 1<u>933</u> Months Days 1X M 2□ F Maryland 74 Director 2**13-**28**-925**1 Apr. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Baltimore Halethorpe 1 ☐ Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5232 Arbutus Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

12 Yes 2 No 195
If Yes, Give
Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1951-1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ Specify: 3 Widowed 4 Divorced 1953 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward LeRoy Rottman, Sr. Eileen Horn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 stand 2 stand 2 stand and 1 mportant: If item 27 is any injury or other trau once. Betty Rottman, Wife 5232 Arbutus Ave., Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Meadowridge Memorial Park Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-17-2008 Elkridge, MD thre Fune of Service Licenses 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Suulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) at LOSILO **Physician** a 700 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one | Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of gertitier 29c. License number 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print) 20 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAR 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** Alma L. Reed 0 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4500 Carleview Road **Baltimore** N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F Hours Director 219-20-6897 Aug 14, 1920 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Directo 1 XYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4500 Carleview Road 21207 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ğ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Pages 1 and 2 should be filed nent of Health and Mental Hyginnt: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Waddell Mitchell Ethel Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellsworth Vincent 4500 Carleview Road Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 03/18/08 Owings Mills, Md. Garrison Forest Veterans Cemetery permit. 21. Signal 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) Melanoma **Physician** menth /Medical Due to (or as a consequence of) Examiner bequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Thysician and s the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of) Physician/Medical SB IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2. No been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page slipidemia certificate 1 Yes 2 No 25. Was case eferred to medical examiner? Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 100 Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

State

29b. Signature and title of certifier

P.O. Box 68760.

Records,

or Vital

the

29d. Date signed (Month, Day, Year)

0 W. Northarn Physy #101 Baltimore Manyland 21210

and manner stated.

32 Registrar's Signature

Sept Bus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ralph John Ricketts, III 2008 12:55 P M March 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 710 Villager Circle Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth APR 9 1957 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland Days Hours Months 1XM 2□F 219-66-8844 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 710 Villager Circle USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u> Automotive Parts Manager</u> Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ricketts Evelvn J. Horne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Gale Ricketts - Wife 710 Villager Circle, Dundalk, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 3/17/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams 22 Cremtion Society of Maryland, Inc. Hule 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RECTAL CARCINOMA METASTAT IC 2 YEARS GMONTHS resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed'

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within 73.
Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "ns any injury or other traumatic event, the Medis once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

2

MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and physician within 24 hours after death

To the Funeral Director:
completely filled in by the it

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Examine Physician/Medical Completed by Be Jo Medical Certification:

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 Unknown

25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome 5 Residence 6 □Other (Specify)			
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury	28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, of building, etc. (Specify)			ffice	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a.	Certifier
	(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Christian Frederick Meyer NI	D61769	March 17, 20

30. Name and address of person who completed cause of death (Item 23st) (Type, Print) CHRISTIAN FREDERICK MEYER ORLEANS STREET BALTIMORE MARYLAND

Registrar

0

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AVEN TIEM 26 per PHYS 0877 3/18/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** Kuff 2:30 PM 2008 Grace 3 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 20 A Glen Creek ElKton Cecil If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 171-44-1179 Pennsylvania **Director** 12-22-1950 Usual Residence of Decedent with the Maryland r 28a-f show notified et 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ceci 1 XYes 2 □ No ElKton Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ırai", or Items 23a or Examiner must be ı 7G1 Gilen Creek Circle USA 21921 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5-0036 "natural", or Specify: Black 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medicel 2121 Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Laborer mportant: If item 27 is marked other Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth field Altermease Chatman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yaisha Ruffin/Daughter 20A Gilen Crack Circle Elkton, mp 21921 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H 1 Surial 2 □ Cremation 3 □ Removal from State 3-20-2008 Philadelphia, PA Mt. Peace Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cordoza Jacks Funeral Home 21. Signature of Funeral Service Licensee YN01358 1403 N. Franklin St. Philadelphia, PA 19122 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reas anc /Medical Due to or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the deeth certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. page 2 s autopsy perform certificate has 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one Other: 4 Nursing Home 5 Hesidence 6 X Other (Specify) Hospital: 1 ☐ Yes 2 🔽 🗡 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Matural 5 Pending investigation in 24 hours after death, the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely To th. within 2. and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) 32. Registrar's Signature State Registrar

Q

### 08-01699 Ronald Lee Ray

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

onaid Lee Ray		State of Maryland / Department of Health and Mental Hy  I-For State  Certificate of Death	giene Reg.	No 201	10 0070	
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death	
ledical Exami	ner	Ronald Lee Ray	Month E February 28		1525 hrs	
4		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1314 Hollins Street Baltimore		4c. County of Dea	tn	
Funeral		5. Social Security Number 111 k 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth		irthplace (State or Foreign	
Director		1 X M 2 F 60 Yrs. Months Days Hours Min.	Oct 31		country) unk	
*		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
ow any		10a. State 10b. County 10c. City, Town or Location Baltimore			1 X Yes 2 No	
Aaryland 28a-f show 1 at once.	cto	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	A1.	
he Ma 1 or 28 ified 3	Director	1314 Hollins Street 21223		USA		
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho tranmatic event, the Medical Examiner must be notified at once.	eral	11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spring Advisor Department)			erican Indian, Black,	
r death or ite	Funeral	1 Yes 2 Nunk	rticari, etc.)			
rs afte ural", miner	ā	Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify.  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	ork done 1	Specify: 6b. Kind of Busines	white s/Industry	
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retin	ed) unk		unk	
1036 Athin 72 ene. or than Medical	E E	unk unk				
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	ပိ	17. Father's Name (First, Middle, Last) unk 18.Mother's Name	(First, Middle, Ma	iiden Surname)	unk	
212 uld be Menta marke	<b>m</b>	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R	ural Route Numb	er, City or Town, Sta	ate, Zip Code)	
and 2 shou lealth and N tem 27 is n traumatic		O.C.M.E. 111 Penn Street Balt	imore, N	4D 21201		
Fe, L s I and f Heal ff item er tra	1	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State	
imore Pages   ment of F lant: If i		4 Donation 5 X Other Specify: in state				
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  State Anatomy Board	655 W.	Baltimore	Street	
Physician	$\rightarrow$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or		t, shock, or heart	Approximate Interval	
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease Death				
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
`-	er	Sequentially list conditions, if any, leading to immediate but to (or as a consequence of):			+	
_	Examine	(Disease or injury that initiated Due to (or as a consequence of):				
uted nd ransit		events resulting in death) Last Due to (or as a consequence or):  d.				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Medical	UNPENDED				
760, ficate be g physici the buri		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance	nev	23d. Date of deliv	ery Day Year	
Box 687: death certific.	iciar	past 12 months?  4 Pregnant at time of death  5 Other (Specify)	ricy	Worth	Day Teal	
Bo ne deat the at	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	(00 - D) (14 - 1		to the cause of death?	
ires that the signed by I be detache	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic alcohol abuse	1 Yes		robably 4 Unknown	
ords, w require is been sig should be	Completed	CHIOTHS district abuse	24a. Was ar		autopsy findings available	
COF e law r e has b	mple		autops	ned? death		
Vital Rec ysician: The his certificate		25. Was case referred to medical 26.Place of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of Death (Check of D	1 Yes 2	No 1 <b>✓</b>	Yes 2 No	
Vita hysician this cer	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other; Nursing Home 5 Residence 6 ✓ Other: Scene				
on of lending Pheath.  or: After the funeral	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred		
Sion vitend death. ctor: y the f	atio	1 V Natural 5 Pending 2 Accident Investigation			D. I.D. I. Markey Gib	
Division of Vital Records, pital or Attending Physician: The law requirours after death.  eral Director: After this certificate has been sfilled in by the funeral director, page 2 should to	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, Sta		Rural Route Number, City	
Hospit Puner: Funer: lely fill		1298 Centiler				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.		nd place, and due to	the cause(s)	
F > F 0	ž	29b. Signature and title of certifier  29c. License number		29d. Date signed (		
		Panyle Fruthall, MB O.C.M.E.		February 29, 2		
	- 8	30. Name d add ss f person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	/ID 21201		7	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature						
State 31. Date filed (Month, Day, Year)  Registrar  MAR 1 8 2008						

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryland / De	epartment of H Certificate of I			ene g. No:2008	08789
,	Physicia	-	Decedent's Name (First, Middle, Last)     HANKA		ROZENCW	AIG	2. Date of Death Month MARCH	13 2008	3. Time of Death 9:20A M
	/Medic Examin		4a. Facility Name (If not institution, give str	, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	4b. City, Town, or	r Location of Death		4c. County of Death	
-	» <u>.                                    </u>		813 SMOKE TREE R 5. Social Security Number 6. Sex	OAD 7. Age (In yrs. last birth	PIKESV	ILLE If Under 24 Hrs.	8. Date of Birth	BALTIMO	
	Funeral Director		212-52-9361  Usual Residence of Decedent	7. Age (111 yrs. last bittle 86 Yr	Months Days	Hours Min.	10/21/1	Year) 9. Birtili 1921	place (State or Foreign POLAND
	ryland how Lat		10a. State 10b. County	10c. City, Town o	or Location				0d. Inside City Limits
	Ba-f s	Director	MD BALTIM	ORE PI	KESVILLE				1 ☐ Yes 2 No
	with the a or 2 be no		10e. Street and Number	A D	10f. Zip Code	01000	10	g. Citizen of What Cou	ntry?
	death ms 23 must	Funeral	813 SMOKE TREE RO	Was Decedent Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	21208 lispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Americ	
036	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuba 1 ☐ Yes 2 ANo	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White, Specify:	etc. WHITE
2	72 ho 'natur dical I	eted	15. Decedent's Educa (Specify only highest grade	tion 16a. D	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	ation during most of worki	ing 1	6b. Kind of Business/In	dustry
Maryland 21215-0036	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	IIITE. DO NOT use retired HOMEMAKE			OW	N HOME
2	should be filed and Mental Hygi marked other matic event, ti	Be Co	17. Father's Name (First, Middle, Last)		TIOTIET!	18. Mother's Name	(First, Middle, M		110112
<u>/lar</u>		TO B	YOSKE	ZAGDANSKI		ITA		CY.	TRYN
Jan	2 s ar is		19a. Informant's Name/Relationship (Type BERNARDO ROZENCW	·	Mailing Address (Street				o Code)
	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition	20b. Place of E	319 LAGES L	1 1	TIMORE,	20c Location - City or T	own, State
E O	00		1 🕅 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other ( <i>Specify</i> )	moval from State WODMOO	MONTE TORE R HEBREW CO	NG. 03/16	5/2008   E	BALTIMORE,	MD
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice see		22. Name and Addre	ess of Facility SC	L LEVINS	SON & BROS. PIKESVILLE.	, INC.
ľ	2 33		23a. Fa 1. Enter the disease, or complice his ck, or heart failure. List only one	ations that caused the death. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Imm o ate Cause (Final disease or condition	Myoca	rdial =	Infan	retion	<b>/</b>	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a con equence of	scleros				
		Jer	Sequentially list conditions, if any, leading to infinediate	Due to (or as a consequence of	):	>			
	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events conditions to the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditio						
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	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Urector After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) 1 ★ Certifying Physical Examin	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the ti /or investigation, in my	ime, date and place, opinion, death occur	and due to the carred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	0.	29c. Licens		29	od. Date signed (Month	, Day, Year)
	0	1	Murylus	allu MD		10718		5/14/200	78
	7		30. Name and address \ person who con HARRY M. WALEN M.	npleted cause of death (Item 23a) (T 2700 Qvarry LA)		ALTIMOR	E MD.	21209	
Ì	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Registr	ar	MAR 1 8 200	X Markey M	BORGE 0				

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6.55 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 4, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🔀 F 220-24-7477 78 Mary I and Yrs. Director Usual Residence of Decedent Maryland 10c. City, Town or Location Baltimore 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☑ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must he no 1 W. Conway Street Apt. 416 21201 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Bollinger Albertina Karcher ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James T. Russell/Nephew 11 Cool Meadow Court Baltimore Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 3/22/08 Baltimore Maryland 21. Signature of Funeral Service Licensee-22. Name and Address of Facility IEOnard J. Ruck, Inc mistin h 5305 Harford Road Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACRANIAL HEMORRHAGE MASSIVE **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed this certificate 2 1 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 mpatient ို 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO61789 MARCH, 14, 2008 richino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWUAH. STOI LUCH LAVEN BLUD, BALTIMORE MD 21239 OXOR ARRAINE 32. Registrar's Signature 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		of Marylar			nt of H			lental Hygi	ene ( g. No.	006	08792
Physicia /Medica		1. Decedent's Name (First, Middle, La Mary R	egina		`					2. Date of Death Month March	Day 15	Year 200	
Examine	ř	4a. Facility Name ( <i>If not institu</i> tion, giv Stella Maris Hos		umber)			y, Town, or Monui		of Death			altimo	
Funeral Director			Sex 1 □ M 2 □ MF	7. Age (In yrs. 88	last birthday) Yrs.	If Und Month	ler 1 Year s Days	ff Under Hours		8. Date of Birth Juneth, 22,	4919	9. Birt M <i>S</i> 9	hplace (State or Foreign
death with the Maryland me 23a or 28a-f ehow Litual be notified at	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Carrol  10e. Street and Number	1	10c. Ci	ty, Town or Lo	svil	le			10	g. Citizer	of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
after after	Funeral Director	119 Schoolhous  11. Marital Status  1 Never Married 2 Married	12. Was De Armed F 1  Yes	2 (1No	ı	Was Dec f Yes, sp	ecify Cuba	n, Mexican	igin? (Spe 1, Puerto	acify Yes or No- Rican, etc.)	14.	-S-A- Race - Ame Black, White	e, etc.
thin 72 hours e	Completed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed	Dates:	16a. Deced (Give life. L	ient's Us kind of t	vork done d use retired,	Specify: Ition Juring mos	t of worki	ng 1	6b. Kind	of Business/	•
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Permit. Pages 1 a Papertment of He mportant: if Itam my injury or other most.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci	<i>(y)</i>	_ 1 1		natory o	n. Gal	dens	Mar	ch 18,20	08 м		tsville, MI
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the Hos hin 24 ho the Fun pletely	leologi eologi	one) 2   Medical Exam	niner: On the	pasis of examina nner stated.	ation and/or inv	estigation	on, ⊮n my op	inion, dea	th occurre	ed at the time, da	te and pla	ace, and due	to the cause(s)
To To con	3	29b. Signature and fittle of certifier			_	2	9c. License D4		15			-	h, Day, Year)
7		30. Name and address of person who Tanka Mahr	completed cat	use of death (Iter	m 23a) (Type, Rids	Print)	d	We	otm	unste.	rn	10 2	4157
State	-	31. Date filed (Mor(th, Day, Year)		Registrar's Sign:	ature				<u> </u>				

ORIGINAL

# SZIMANSKI, JOHN 3.6.08 7:16PM Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2008 7:16 AM March 6, /Medical John E. Szimanski Jr 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1**X**]M 2□ F Months Hours Director Aug 27, 1951 56 Maryland 217-56-8402 death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ▼Yes 2 No Examiner must be notified Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21219 USA 2513 Marine Avenue or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give unk 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2X No If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk than, permit. Pages 1 and 2 should be filed within D partment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the IM of prime. Elementary/Secondary (0-12) College (1-4or 5+) 12 security officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John E. Szimanski Sr Carrie Hewitt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gilchrist Hospice 555 Towsontown Blvd Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. B Baltimore, MD 21201 1a. P. 11. Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Immediate as se (Final disease or condition resulting in death) a. WROWNOW M35. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death MOTVIHS Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 281 No has page certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Tes 2**X** No Hospital: Other: P 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Jospina ... 4 hours after death. Funeral Director: After this seried in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral I the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 7, 2008 064395

Registrar

NCHARLES ST, STUTE 209

BALTIMORE, MOZIZO4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 6565 N 32. Registrar's Signature

Labore 1

DANIEUE DOBERMAN: MO

MAR 1 8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ам Loretta M. Simpson March 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore Stella Maris Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🕅 F 100 Washington DC 578-38-9666 09-06-1907 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Harford 1 ☐ Yes 2X No Jarretsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3609 N. Furnace Road 21084 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William W. Mansfield <u>Josephine May Gross</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3609 N. Furnace Rd., Jarretssville, MD Anne Lynn King / Daughter 21084 20b. Place of Disposition (Name of the cemetery, crematory on other Hillop Service Corporation 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 03-18-2008 Towson, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C/5523 E Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

**Funeral** 

Director

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r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

2 should be filed within 72 hours after of and Mental Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event,

Baltimore, Maryland 21215-0036

11:00 A.M

2008

burial-transit

E B physician funeral director, page 2

Box 68760 LORETTA SIMPSON MARCH Division or Vital Records, P.O. Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified To the Hospital within 24 hours at To the Funeral D

State

dical	•	d		-6.		
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □ Ectopic p 4 □ Pregnant at time of death 5 □ Other (s 9 □ Unknown			23d. Date of delivery Month Day	/ Year
ed by Pi	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying	cause given in Part I.		ouse contribute to the ca	
Complet				24a. Was an autopsy performed? 1  Yes 2 →		
Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
일	1 Yes ≥No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D	OOA Other: Nursing Ho	me 5 Residence	6 □Other (Specify)	
	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M		28d. Describe how in		
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, facto building, etc. (Specify)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Ro te)	ute Number,
Medical (	one) 2 Medical Exam	/sician: To the best of my knowledge, death occurre- iner: On the basis of examination and/or investigation and manner stated.	d at the time, date and place, on, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stated and place, and due to the	d. cause(s)
Σ	29b. Signature and title of certifier	and Die	9c. License number		Date signed (Month, Day,	, Year)

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY ROAD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D.

MAR 18

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 13, 2008 Year **Physician** Seidlich 11:15 PM Nellie /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 8 - 29 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 6. Sex 1 □ M 2 X F Months Days Hours Min. 89 212-05-1305 Director Maruland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anne. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Severna Director Maryland Anne Arundel **Yark** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Compani Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Klunk WIIIIam Margaret Struchcomb ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severno )awant Hark, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD Woodlawn 3-19-08 'errutarij 4☐Donation 5 ☐ Other (Specify) 21. Signeture of Fundant Sorvice Licensee 22. Name and Address of Facility Ruck Funeral Home, Inc. Towson. Approximate Interval Between Onset and Death HS Mrs. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** terrioras /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPRIONED BY MEDICAL EXAMINES Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Dementia 4ears Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical SS IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Dav Year 1 ☐ Yes 2 🕅 Xlo 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ YNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate ha 1∐ Yes 2 X No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XXYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 Natural s after dec. Subject fell 14:30 PM 1 ☐ Yes 2 No 2 X Accident 3-12-08 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) Columbia, MD 8220 Snowber River Plwy 4 Homicide Nursing within 24 hours aft To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) MAR 1 8 2008 DHMH 17 Rev 1/2001

10700 Charter

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Albert, MD

065776

March

Dr. Suite 200 Columbia, MD 21044

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , 2008 Month March 16, 2:53 PMM Santa Serio Maria 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Hours Min. Months Days 218-14-6033 83 Oct. 7,1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21228 6112 Wheatland Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Rose Lucido Sansone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Hall, Maryland 21120 5109 Bright Owl Road Samuel Serio Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 3-21-2008 Baltimore 4 Donation 5 Other (Specify) 21. Si majure. F 22. Name and Address of Facility Total Service Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final weeks disease or condition resulting in death) Due to (or as vo insequence of): 5 VCA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 WAnor Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1∏Yes 2∏No 2 ☐ Accident

The law requires that the death certificate be executed attending physician and Records, P.O. Box 68760 signed by the page 2 s After this certificate Division or Vital or Attending Physician: within 24 hours after death

To the Funeral Director; of completely filled in by the f Hospital the

March 16, 2008

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show must be notified at

23a or

or items

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.

**Physician** 

/Medical

Examiner

Examine

Physician/Medical

Completed

Be

Medical Certification: To

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

Be 2

with the Maryland

3 ☐ Suicide 4 Homicide

6 Could not be determined

2008

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

N. Charle St. Balto. Ms Zc 20x

29b. Signature and title of certifier

(Check only one)

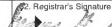
30. Name and address of person who completed cause f death (Item 23a) (Type, Print)

6701

29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)



		1	For State Registrar		•	Cer	tificate of I	Death		F	Reg. No.	008	08	191
	15		1. Decedent's Name (First, Middle, Las	")						Date of Dea	Davi	. Year	3. Time o	
. W	Physicia /Medic		Marian Elizabet	h Smith						March	16	m 2009	8 18:0	) <del>T</del> M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or				4c. C	ounty of Deat	h	
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	uneral		5. Social Security Number 6. Se	7. Age	(In yrs. las	it birthday) Yrs.	Months Days	Hours	Min.	Date of Birt (Month, Day	y, Year)	Co	hplace (State untry)	or Foreign
æ D	irector	-	220-24-9943 Usual Residence of Decedent						A	oril 2	29,19.	30 Ma	ryland	
/land	at		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside C	
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ballimor bermit. Pages	Department or result and menter riggers.  Department or result and menter riggers.  By Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1		matory or other pla Mem. Pai		3/18/20	008	Sykes	ville,	Mary1	and
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per per	any	h d	Market	1 Hens		F	uneral H 630 Edmor	ome o: ndson	t Cato Avenu	nsvil e: Ca	.le, l tonsv	ille.	MD 212	28
100	1		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused	the death.	Do not ent	er the mode of dyi	ng, such as	cardiac or re	espiratory a	rrest,		Approxima Interval Be	ate etween
Phy	ysician	et b	Immediate Cause (Final disease or condition	Λ	OXIC	E	VCEPHA	LOPE	Y H TF			3	Onset and	
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the	within 24 hours arter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one) 29b. Signature and title of certifier	and manner sta				se number			29d. Date	e signed (Mor	ith, Day, Year)	)
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2 1	Sta		31. Date filed (Month, Day, Year)	32. Pojistra	ır's Signatı	ure								
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DHMH 17 Rev 1/2001

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MARIAN

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:20 A M 200x **Physician** Sarah W. Sullivan Tirch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore Roland Park Place 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M & F 90 Massachusetts 218-52-0693 1-13-1918 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at ty⊈Yes 2 No Baltimore MD N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 830 W. 40th Street 21211 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes ♀反 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2**XX**X0o Specify: Baltimore, Maryland 21215-0036 Specify: white þ ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "1 Elementary/Secondary (0-12) College (1-4or 5+) In own home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Skyles Eleanor Richard Whitall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun once. 4 W. Highfield Road Baltimore, Maryland 21218 Sarah Robinson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 3/18/2008 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee—Henss—Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21. Signature Funeral Service Lice 21211 Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one case Immediate Cause (Final disease or condition resulting in death) Parkerson's Ohdease and - Stage Years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t I be deta Division or Vital Records, β Walter elective cardowareneous 2 No 3 Probably 4 Unknown Be Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 12 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 27. Mann Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. ne Funeral Director: Af bletely filled in by the fur 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

within 24 hor To the Fune completely f

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MARELIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Black

Medical

State

Registrar

1 (Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MARGREGIR, 830 W 40 / STREET, BALTITURE, MD 21211

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D13657

29d. Date signed (Month, Day, Year)

March 17,2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200 B Month Dav **Physician** ABRAHAM :40 P MARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner HOSPITAL RANDAUSTO BAUT IMORE NORTHWEST 9. Birthplace (State or Foreign Country) RUSSIA 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 218-09-2154 Director 88 04/19/1919 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 7415 REMOOR ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify Specify: 2 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHAROKY ALTER MAX SOPHIE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY LIEBERMAN / NEPHEW 11007 VALLEY HEIGHTS DRIVE, OWINGS MILLS, MD 21117 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) WORKMEN CIRCLE 03/14/2008 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Jatt 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Cevins 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ATHEROSCIEROTIC CARDIO VASCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Tyes 2 □ No 3 Probably 4 VUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 V No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No use the within 24 hours after deam. To the Funeral Director. After this control of the funeral director. 1 ☐ Yes 1 Inpatient ဥ 2 ☑ ER/Outpatient 3 DOA 27. May er of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 RANDAUSTOWN MARYL ROTAKIN COAD MILHAEL OUD COURT 5 YO1

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR

32. Peristrar's Signature

2008

8

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2008 1745 Schoff Nina March 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Cecil If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/29/1956 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 0 F Director 218-70-7732 51 MDUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the firem 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits a or 28a-f show be notified at 1 ☐ Yes 2 No Director MDHarford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2205 Arden Dr 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine Operator Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Yaroshevich Ευα Svatey P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fallston, MD. 21047 Eva Bryant 20a. Method of Disposition Arden Dr. (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Donation 5 ☐ Other (Specify) $Andrews_Orthodox$ | 03/17/2008 | Dundalk, MD. Signature of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, MD 21222 Dundalk, Inc. 7922 Wise Ave. 23 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hooxic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine physician and the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FFMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a 9 ☐ Unknowe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform SOCO 2 No sceest 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred

or Attending Physician; The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. After within 24 hours after death.

To the Funeral Director: completely filled in by the f the Hospital

funeral

Medical

Certification: To Be 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide 4 ☐ Homicide (Check only

5 ☐ Pending investigation

6 Could not be determined

28b. Time of 28a. Date of Injury (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cordon Coksoucon MD 223 WMain St. Elkhon, MD 21921

000060756

311512008

State Registrar

31. Date filed (Month, Day, Year) 2008 8

MAR

29b. Signature and title of certifier

32. Registrar's Signature

( DEAL)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician 200⁸ 15, 10:30 A M Howard Cyril Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 4250 Blue Barrow Ride Ellicott Citv If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, MAR 14 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□ F 87 New York 1921 060-16-4211 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 ☐ Yes 2 No Funeral Director MD Howard Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be 4250 Blue Barrow Ride 21042 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No if Yes, Give Year or Dates: 42-4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify: 3 Widowed 4 □ Divorced 42-45 White nt of Health and Mental Hygiene. If Item 27 is marked other than "natu or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Human Resources Shell Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Newton R. Thompson Helen Moriarty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4250 Blue Barrow Ride, Ellicott City, MD Mark G. Thompson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any Injury or Metro Crematory, Inc. 3/17/2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams 21228 tu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, liany, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ling physician and eas the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 □Unknown 1 🗌 Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performed? 1 Yes 2 You certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2000 Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) မ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No n 24 hours after death. Per Funeral Director: A pletely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Medical within 2

State

Registrar

31. Date filed (Month, Day, Year) MAR 18

29b. Signature and title of certifier

gistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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29c. License number

29d. Date signed (Month, Day, Year)

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5 Uniered by Funeral Director	202-36-5262	street and number)  al Center  x 7. Age (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	16a. D	or Location  ille  10f. Zip C  21  13. Was Deceder If Yes, specifit   Yes 2 [	Days Hours Min.  Days Hours Min.  Days Hours Min.  234  It of Hispanic Origin? (S  Cuban, Mexican, Puer	Marylar B. Date of Bir (Month, De 09/20/	Day 16 2 h 4c. Count and Balt th ay, Year) 1912	y of Death timore 9. Birthplace Country) Montar  10d.  What Country's ce - American lack, White, etc.	Inside City Limits 1 ☐ Yes 2√ No
	St. Joseph Medica 5. Social Security Number 6. Se 202–36–5262 Usual Residence of Decedent 10a. State 10b. County MD Baltimon 10e. Street and Number  8830 Walther Blve 11 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)  Andrew Allan	street and number)  al Center  x	95 Yr 95 Cc. City, Town of Parkv: 817 Par in U,S.	Months or Location ille 10f. Zip C 21 13. Was Deceder If Yes, specific 1 Yes 2 [ Decedent's Usual Give kind of work	TOWSON, Year If Under 24 Hrs Days Hours Min.  Dode  234  It of Hispanic Origin? (S Cuban, Mexican, Puer	03 Location of Deat Marylar B. Date of Bis (Month, De	16 2 h 4c. Count and Balt th 1912 10g. Citizen of U.S. 2	y of Death timore 9. Birthplace Country Montar  10d.  What Country? A. ce - American I	e (State or Foreig 1a Inside City Limits 1 □ Yes 2√ No o
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2	Marion T. Root (	daugnter)	20b. Place of D	Disposition (Name	a Court - E	Date		- City or Town,	
	1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	cemetery,	crematory or oth	er place)	3/18/08			
	4 ☐ Donation 5 ☐ Other (Specify)		Metro (						
1,	21. Signature of Funeral Service Licens	/ - /		11750 B	E. elair Road	F. Las: - Kings	sahn Fu ville, 1	neral H Marylan	ome, P. d 2108
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5 F	Part II. Othar significant conditions cor	ntributing to death but n	ot resulting in t	he underlying cau	se given in Part I.	23b. Did	tobacco uaa co	ontributa to the	a causa of dea
	()	1 1	1100			1 🗆	Yaa 2□ No	3 Probab	ly 4 Unkno
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3								24b. Were availab	autopsy findings ole prior to etion of cause
<u> </u>								of dea	ation of cause th?
5						10	Yes 2 No	1 □ Ya	as 2□ No
					26. Place of De	ath (Check only	one)		
<b>o</b>	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient	2 KER/Outo	atient 3 DOA	Othor			her (Specify)	
		28a. Date of Injury	28b. Tir						
	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORD, Day 1)	our, mil	M	1 Yes 2 No				
3	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	- At home, farm	n, street, factory, o	ffice	28f. Location (	Street and Num	ber or Rural Ro	oute Number,
	. LI TIOMINADO	Dunging, etc. (S	opeony)			0.1, 0.70	,		
-	29a. Certifier 1 ☐ Cartifying Phys (Check only one) 2 ☐ Madical Examl	nar: On the basis of ex	amination and/	death occurred at or investigation, in	the time, date and place my opinion, death occu	e, and due to the irred at the time,	cause(s) and m date and place	nanner as state , and due to the	d. cause(s)
		wind married states		29c. I	icense number		29d. Date sign	ed (Month, Day	, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me 28/7,03/14/08dhb Reg. No. Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year ora ANN homas 1745hx February 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Baltimore HOSpita If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 534 1 □ M 2 🔀 Director aryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 es 2 No timone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ク by Funeral Jenue Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced ac Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)  $\infty k$ 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname ၉ 19a. Informant's Name/Relationship (Type. Crivaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2020 Batto-MD2121. Ireshawna NorthA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removal from State 2008 21. Signature of Euneral Service Licensee M61363 RCL 23a. Part1. Enter the disease, or contributions that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** N eno Ripplehin /Medical Due o (or as a consequence of) Examiner Sequentially flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death Month Year Day 5 ☐ Other (specify) the detached 9□Unknown 9 🗆 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 110 1☐ Yes the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes -2 3 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation Unknown unknown^M 1 Tes Unknown 2 Accident 2 No **Director:** 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown Unknown vithin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number P tebruary 16,2008 30. Name and address of person who completed cause of death (Item 23a) (Type OWI

State Registrar 31. Date filed (Month, Day, MAR 1 7

2008

32. Registrar's

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylar		artment of H tificate of L			giene Reg. No. o o o	0 00001
0	Physici	an	1. Decedent's Name (First, Middle, Last) Dorothy P. Tr	acy				2. Date of Dea Month MARCH	Day Yea	A AN PH
	/Medic Examin		4a. Facility Name (If not institution, give Union Memorial			4b. City, Town, or Baltimo	Location of Death		4c. County of De	
	Funeral Director		5. Social Security Number 6. Sec		. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day March	h las	Birthplace (State or Foreign Country) ryland
pu	2		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
Maryla	f sho	ro	Maryland N/A		Baltim					Yes 2 No
t e	r 28a	Director	10e. Street and Number			10f. Zip Code		T	10g. Citizen of What	Country?
ath wif	23a o ust be	ralD	312 W. 31st Stree	:t		2121			USA	
d 21215-0036 filed within 72 hours after death with the Marvland	if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2⁄2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	- 14. Race - Ar Black, W Specify:	merican Indian, hite, etc. White
9	atural cal Ex	Completed by	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	. 1	16b. Kind of Busines	ss/Industry
Maryland 21215-0036	an "n Medi	nple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	1	kind of work done of NOT use retired		king	Enoch P	ratt
<b>7</b> %	Hygiene ther thai	S	Unknown		Bind	ing Depar		o (First Middle	Librar Maiden Surname)	У
מחם קרום	and Mental Hygi is marked other aumatic event, t	) Be	17. Father's Name (First, Middle, Last) Arthur Sprigle					gie Garo	,	
aryla should	nd Me mark umati	2	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town, State	
, <b>M</b>	n 27 is		Michael Tracy	Son		W. 31 St		· ,	Maryland	
ore Far	nent of Health int: If Item 27 i		20a. Method of Disposition  ★□ Burial 2 □ Cremation 3 □ F	lemoval from State	Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. Location - City	
	tant:		4 □ Donation 5 □ Other (Specify)  21. Signature of uneral Service License	1		Cemetery		/2008	Woodlawn,	_
g a	Depar Impor	a	hum le	3. Henss	3	osi ralis	Road, B	altimore	l Home, In e, Marylan	a
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ications that caused the dea ne cause on each line.				or respiratory a	rrest,	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		EP SI	-2			2 Hays
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1/19	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of).					
68760, C	physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
	physic the b	edical		d						
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr					23d. Date of	delivery
F.C. G	y the atte	Physician/M	in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 2∏Fe 4∏Pregnant at time of 9∏Unknown		□Ectopic pregnancy □ Other (specify)	/		Month	Day Year
	been signed by the should be detached	ρ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did t		e to the cause of death?  Probably 4 Denknown
9 S	has bee	Completed						24a. Was	psy prior	e autopsy findings available to completion of cause of
ב ב	cate h	Con						perfo 1□ Yes	ormed? death 2. No 1□	n? ∕es 2□No
or Vita	certifi	Be	25. Was case referred to medical examiner?	Hospital:		nt 3 🗆 DOA Oth	26. Place of Dea		•	
o g	er this	7: To	1 Yes 2 No	28a. Date of Injury	28b. Time o	W OLI DOX	4 🗀 Nuising n		dence 6 Other (5 how injury occurred	specity)
VISION	death. <b>ctor</b> ; Aftu y the fun	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
= 5	after de I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office		28f. Location ( City or To	Street and Number or wn, State)	r Rural Route Number,
To the Hospital	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C		rsician: To the best of my kr iner: On the basis of examir and manner stated.						
Tothe	within To the compl	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
			MAHON ARINA	160 SIHAM,	M.S	ATE	24389	46	MARCH 1	4 2008
	5		30. Name and address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can address of person who can addre	ompleted cause of death (Ite	em 23a) (Type,	Print)	WEAL II	MEATTI	H. BAIT	LMORE, MD
	Sta	ete.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature_	MAM	URLALI	1001211	)	,
	Sia	ite	MAD 1 9 2	nns Dates	1	boardes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per ind 887/3-18-08vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Vanvary** Thomas Month Physician 4:40 p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Genesis Homewood N/H Baltimore if Under 1 Year if Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 M 2□ F MD Director 219-19-6751 9-6-1966 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in returnal; of items 23a or 28a-f show Important; if them 27 is marked other than "ratural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Baltimore Director N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 602 Parkwyrth Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 ☐ Married Black 3altimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never worked Never worked 9th grade N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Scott Edward McKay 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Parkwyrth Avenue Balto, MD 21218 19a. Informant's Name/Relationship (Type. Print) Edward McKay - Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 □Removal from State 3-5-2008 Baltimore, MD Greenmount Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H East 21. Signature of 5 neral Service ic 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Jumano & Laienan **Physician** Sorinpt /Medical Due o (or as a consequence of): Examiner Kallenon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): OLE ಗೂರ್ ಜ್ಯ Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t. d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: SE No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 Yes 2 Accident after death 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I 1 dedifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sports 12 when I 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOYOU 6.49 32. Restrar's Signature 31. Date filed (Month, Day, Year) State MAR 18 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		Registrar Certificate	of Death	Reg. i	No.
Physici edical Exam		James Earl 1	unstall, Jr	2. Date of Death Month Da March 1, 200	8 1540 nrs
		Facility Name (if not institution, give street and number)     Sopwith Drive Apt. H	4b. City, Town, or Location of Dea Middle River .	th	4c. County of Death Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24H	rs. 8. Date of Birth(N	//////////////////////////////////////
Director			Yrs. Months Days Hours M	in. 10-16-	1955 Foreign Country) N.Y.
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
* .	L	MD			1 Yes 2 X No
aryland 8a-f show at once,	cto	MD Baltimore Middle 10e. Street and Number	e River	10g.	Citizen of What Country?
the Main or 2 or 1 or 1 or 1 or 1 or 1 or 1 or 1	Director		21220		USA
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer		14. Race - American Indian, Black, White, etc.
er dea			Yes 2X No specify:	,,	Specify: Black
urs afi tural' aming	d b	or Dates:	edent's Usual Occupation (Give kind o	f work done 16	b. Kind of Business/Industry
72 ho n "na al Ex	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use r	etired)	,
5-0036 iled within 72 Hygiene. I other than the Medical	Comple	l2th grade unk	Shipping Cler		unknown
15-00 filed with Hygien d other the Me	ပိ	17. Father's Name (First, Middle, Last)		me (First, Middle, Maio	den Surname)
ID 21215-003 should be filed within and Mental Hygiene. It is marked other the natic event, the Med	To Be		IMATTI ailing Address (Street and Number of	e Martin	City on Tayon Chair 7in Code)
	Ĕ		•		Balto, MD 21202
P P H E W		20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery,	-	Oc. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		Green	or other place) mount Cem 3	-10-08 I	Baltimore, MD
- u u u		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of Facility	March F/1	H Fast
Balt permit Depart Impor injury		Aladas Warrer	1101 E. North		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.			
/Medical		Immediate Cause (Final disease a. Narcotic (Methado	ne) Intoxication		Death
Kallillet		or condition resulting in death)  Due to (or as a consequence of):			
	Į.	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			
	Examiner	causs. Enter Underlying Cause (Disease or injury that initiated			
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executed an and al - transi					
8760, riffcate be ing physicia as the burit	n/Medical	23a 27 28a—  IF FEMALE: 23c. If yes, outcome of pregnancy	f per me g877 3-2	21-08 vt	23d. Date of delivery
587 ertifica fing pl			Fetal death 3 Ectopic preg	nancy	Month Day Year
Box 6 ne death cerr the attendin	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
D. B trithe d by the	P _r	Part II. Other significant conditions contributing to death but not resulting in the	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
P.( es that gned e det	<u>\$</u>		, , , , , , , , , , , , , , , , , , , ,	1 Yes	2 No 3 Probably 4 Unknown
Records, The law require ficate has been si, page 2 should b	Completed			24a. Was an	24b. Were autopsy findings available
e law e has ge 2 st	ᇛ			autopsy performe	
tal Recian: The certificate ector, page			26.Place of Death (Che	1 Yes 2	No 1 ✓ Yes 2 No
of Vital ng Physicians of this certi of the certi of the certi of the certi	o Be		Othor		sidence 6 🗸 Other: Scene
n of ing Ph After t funeral	급 2	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work?	28d. Describe how	v injury occurred
Division tal or Attendin rs after death.  al Director: Aled in by the fu	jë	Natural 5 Pending 3-1-2008 3:35	pm 1 Yes 2 X No	unknown	
ViS or At after d Direct in by	<u>i</u> ë	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.		eet and Number or Rural Route Number, City
spital lours a filled	Certification:	4 Homicide determined (Specify) residence		Middle Ri	601 Sopwith Dr. Apriver, Md.
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the					
To To Com	Medical	and manner stated.  29b. Signature and title of certifier	29c License number	12	9d. Date signed (Month, Day, Year)
		TI , 11. 71	O.C.M.E.	INE	March 2, 2008
A		30. Name and address of person who completed cause of death (Item 23a)	9		
0		Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimo	ore, MD 21201	
		31. Date filed (Month, Day, Year)  32. 8 gistrar's Signature	0		
Regis		MAR 1 8 2008 See 5 6	08 4 / L.		
HMH 17 Rev 1/2	2001	ORIGI	NAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month Physician 0525 A M 2008 ANGEL TERRY March RENEE 13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL Baltimore CIT N/A 8. Date of Birth (Month, Day, Year) 7 Country TARYLAND If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 □XF 215-79-7519 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1X Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5618 GREENHILL AVENUE 21206 U.S.A. Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 🎾 No Specify 2 3 ☐ Widowed 4 ☐ Divorced BLACK Year or Dates: Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STEPHANIE FORD LAMONT TERRY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5618 GREENHILL AVENUE, BALTIMORE, MD. 21206 STEPHANIE FORD/ MOTHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 3/18/08 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 2-Man 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary hypertension cheminth /Medical Due to (or as a consequence of): Complex congenital heart disease **Examiner** 7 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes this certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director; / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number RES - 000 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 13 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sarah Skelton 600 North Wolfe Street Baltimore MD 21287

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITTM/23a pt I TT C877, 3/28/08 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 5.30 BM Tyler James E. Sr. larc 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Anne Center Glen Medical If Under 1 Year 8. Date of Birth (Month, Day, Jan. 15 Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 19<u>56</u> **Funeral** Days Hours 1 ☑ M 2 □ F 214-72-0255 Jan. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Washington Thurston Lacey 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2218 Westlake Drive 98503 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communication Specialist US Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Ε. Tyler Bernice Carroll ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Tyler (spouse) 2218 Westlake Drive, Lacey, WA 98503 Baltimoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 18 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State |Maryland Veterans Cem 2008 Crownsville, Maryland 4 Donation 5 ☐ Other (Specify) Funeral Syrvice Librus 22. Name and Address of Facility 21. Signature Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or complications at caushock, or heart failure. List only one calls on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Diabetes Mellitus Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Box 68760. aftending physician for use as the buria Physician/Medical as t IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 22 No this certificate 1□ Yes Gangrene of left hand 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendi lours after death. neral Director: A death. 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 063726 3.15.0003 0781 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 105 1000 se u NLED 10015 (con 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			-	For State Registrar	oldio oi ma	y.a.r.a.r	Cer	tificate of	Death		Re	g. No	008	08809	
		Physicia	an	1. Decedent's Name (First, Middle, La Fujiko Kikuchi Wh	•					NA.	ate of Death onth CCN 14	Day	2008 ^{Year}	3. Time of Death 11:15 A.M	
	٠.,	/Medio		4a. Facility Name (If not institution, gl				4b. City, Town, o				4c. C	County of Death	L	
	*			Stella Maris Hosp		//	la institution of a col	Tir	MONIUM TifUnder 24 Hr	S 0 D	ato of Righ		ltimore		_
		Funeral Director		219-40-6013	Sex 7. Age 1 ☐ M 2 Ž F	(In yrs. last 78	Yrs.	Months Days	Hours Mir	Ap.	fonth Day,	3,19	29Tochic	lace (State or Foreign stry) Jiken, Japai	1
		land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation		-			1	0d. Inside City Limits	_
		a-f sh	ctor	Maryland Baltimo	ore County	Wind	lsor 1	Mill						1 ∐Yes 2∛Š No	
		th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 8140 Milford Gard	den Drive			10f. Zip Code	21244		10		en of What Cour ted Sta		
a.m.	2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm, Machael Event, Inc. 1 ust be infilled anone.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 점 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2私 No If Yes, Give Year or Dates:	0	1	Vas Decedent of H fYes, specify Cuba I □Yes 2 █ਿੱNo	Specify:	Specify Y erto Rican		S		pariese	
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11:	2121	d within giene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+ N/a	+)		Home Mal					Own Hor	ne	
2008	aryland	uld be file Mental Hy arked othe	To Be (	17. Father's Name (First, Middle, Las Kiyoshi Kikuchi	t)				18. Mother's Na Masa Ki			laiden S	Surname)		
•	Σ	and 2 sho ealth and 27 is ma er trauma		19a. Informant's Name/Relationship Vercera Foster (I		I		g Address <i>(Street</i> Milford						Code)	
CH 14	Baltimore,	Pages 1 and the part of He part: If item ant: If item arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arry or other arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangement arrangem		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3. 4 ☐ Donation 5 ☐ Other (Spec			Fun	sition (Name of natory or other place eral Chaj	pel   Mar	Date . 19 , :	2003	Fo		ll,Maryland	
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				23a. Part 1 Enter the disease, or cor shock, or heart failure. List only	nplications that caused to one cause on each line	the death. D	Do not ent	er the mode of dyi	ng, such as cardi	ac or resp	oiratory arre	est,		Approximate Interval Between Onset and Death	
4		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence	ce of):	16 CI	VCr	717	eas (				_
- 1	1	Examiner		Sequentially list conditions.	b	hrenh	1	Hero	abhir						
	./	Ited Insi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	ce of):	*2							
	>,00	rificate be executed ng physician and as the burial-transi		that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):								_
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		To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 🗌 Fetal de	ath 3□	Ectopic pregnand Other (specify) _	су			23	3d. Date of delive Month	ery Day Year	
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		ne Hospit n 24 hour ne Funera pletely fille	Medical (	29a. Certifier (Check only one)  1X Certifying F 2 Medical Example	Physician: To the best of aminer: On the basis of and manner sta	examination	dge, deat n and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ace, and c ccurred at	lue to the ca the time, da	ause(s) ate and p	and manner as a place, and due t	stated. o the cause(s)	
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•		9		30. Name and address of person who		·			TIMONIUM	i, MD	21093	3_			
		Sta Registr	_	31. Date filed (Month, Day, Year)  MAR 1 8	32. gistra	r's Signature	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 8,20,25 per fh/me, 88/7,03/14/08dhb

Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2008 **Physician** Wilhite Denain Ε. Mary re' /Medical 4ct county of Death Facility Name (If not institution, give street and number) Town, or Location of Death Examiner rimac If I Inder 5. Social Security Number 7. Age (In yrs. last birthday 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 🗙 F Davs 217-54-2934 Director 58 12/05/1949 58 NC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County items 23a or 28a-f show ner must be notified at 1 XYes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. Funeral 2416 Francis Street 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify à 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Crossing Guard School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Claude Whitaker Hallie Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrina W. Cooper / Daughter 20a. Method of Disposition 125 Thomas Guidera Circle, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Lansdowne 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 02/06/2008 Landsdowne, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1 188454 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MAPLE MITTUS Due to (or as a consequence of): e squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nown Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has page 2 : autopsy performed death? 1 ☐ Yes certificate 2□ No 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 1 Yes ZHIN 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hay ras MD. 9 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Da

Year 2008

Registrar's Signature

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			1 - For State Registrar	State of Marylai		ent of Health and	Mental Hygie	ne	00011
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	Dhysia		Decedent's Name (First, Middle, Last)	7			2. Date of Death Month	Day Year	3. Time of Death
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			(nenesis Elde	r Care Nurs	sing tome	Brooklyn	Park	BALTI	MORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday) If U	nder 1 Year   If Under 24 Hr			place (State or Foreign
	Director		216-28-3361 15	M 25 F	90 Yrs. Mon	oths Days Hours Min	MAVA2	1917 M	ARYLAND
-	D.		Usual Residence of Decedent				11119004		11.72
	rylar	_	10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	h the Marylan r 28a-f ehow	cto	MARYLAND BALTI	MORE	1.	DROOKLYN	PARK		1 X Yes 2 No
	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or items 23e or 28e-f ehow int, the Madical Exember must be notilled a	Funeral Director	10e. Street and Number		101	f. Zip Code	10g.	Citizen of What Cou	ntry?
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	dea	ner	4	12. Was Decedent Ever in U	J.S. 13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ameri	
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			shock, of heart failure. List only on	e cause on each line.	un. Do not enter the	mode or dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner	1	resulting in death)	Due to (or as a consec	quence of):				
	- Administra	_	Sequentially list conditions,						
10	D #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quartes of):				
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760,			resulting in deathly Last	Due to (or as a consec	quence of):				
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9	Jing Phys After this Tuneral di	뒫	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Home 5 Residence		(y)
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<u>.is</u>	Attending ir death. ector: After by the fune	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome, farm, street, fac		28f. Location (Stree	t and Number or Rura	al Route Number
Ö	after Dire	Certification:	4 Homicide determined	building, etc. (Speci	(fy)	,,	City or Town, S.		
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_	To th	M	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month,	Day, Year)
			b dal	10000	MD	D 5/501	$\Delta$	2000 1. 17	2000
			30. Name and address of person who con	npleted cause of death fite	m 23a) (Type Print)	00.01		erch 17,	
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18	Sta	te	31. Date filed (Month, Day, Year)	32. Redistrar's Sign.	ature	TOUR TOUR	1 01 004 136	[12	3,001
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Year 745p 3 4a. Facility Name (If not institution, give street and number) 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) Feb. 15, 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 🕱 F 1912 Maryland 96 564-98-7015 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 715 Maiden Choice Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛂 No Specify ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ellen Hook Arthur Bagnall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1935 SW Market Street Drive; Portland, OR 97201 ELizabeth Hyslop Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 3/18/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses on W. M01490 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one)

Medical

3 Suicide

4 ☐ Homicide

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

2122

29d. Date signed (Month, Day, Year)

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Den & w

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Maiden

31. Date filed (Month, Day, Year) MAR 18 2008



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State

Registrar

**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

within 72

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permit. Pages 1 and 2 should be Department of Health and Mental Important; If Item 27 Is marked or any Injury or other traumatic ev

Physician

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24 hours after death Pruneral Director:

within 2

Hospital or Attending

The law requires that the death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

Patient known as: Pearl Williams
Baltimore Maryland 21215-0036

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Bus Station  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAR 1 7 2008	ing ing	T G	20.0	examiner?  1 X es 2 Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death  1 Meatural 5 Pending investigation 2 Accident  28a. Date of Injury 28b. Time of Found 2 Accident 1 Exception 1 Pending 1 Experiment 2 Section 2 Section 2 Section 2 Section 2 Section 3 Section 2 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Section 3 Se	3 DOA Other: 4 Nursing F	ath (Check only one one one one one one one one one one	e) ence 6 Other (Specify) ow injury occurred
and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  BLANC WALLE WD GOOS KILBRIOS AD BATTMONS, WWD 21236  State Registrar  MAR 1 7 2008	lospital or Al hours after ouneral Directly filled in by			4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Station  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my know	occurred at the time, date and place	O'Donne o, and due to the ca	11 St., Baltimore, MD ause(s) and manner as stated.
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March 12, 2008 Year 10:15 P.M Juanita Ε. Williams 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days 1 □ M 2√2 F Yrs. 213-26-5725 September 30, 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2 □No Randallstown Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 3544 Carriage Hill Circle APT T-1 21133 United States of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Administrator Insurance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Williams Viola Cullison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Niece) Debra S. Brugh 49 Millstone Road, Randallstown, Maryland 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial PK | 03/17/08 4 Donation 5 Dother (Specify) Sykesville, MD. 21784 21. Signature of Funeral Service License 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, Maryland 21133 mon a. Part1. Inter the disease, and cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) aspiration preumones weeks Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? con gerfine disease 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

**Funeral** 

Director

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Examine page 2 s

Physician/Medical 2 Completed Be Certification: To

To the Hospital or Attending within 24 hours after death. Director: within 24 hours aft

To the Funeral Di

completely filled in

> State Registrar

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. R. C. Y. C. P.M. (6701 N. Charles St. Balto. Md Z (Z d) se 31. Date filed (Month, Day, Year) MAR 18

29b. Signature and title of certifier

32. egistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

MArch (3, 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 Month WIKANSON 11:05 A M **Physician** March 16, Helen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Essex 310 Locust Avenue Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Days Hours **Funeral** Months 1 ☐ M 2 🕱 F April 4, Maryland 59 1948 212-50-0937 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Essex Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 310 Locust Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 "natural", or 2 3 Widowed 4 Divorced 16h Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Medical College (1-4or 5+) Elementary/Secondary (0-12) is marked other than Cafeteria Worker School 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Bass Joseph Adam Novak ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 310 Locust Avenue, Essex, Maryland permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Richard D. Wilkinson Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) March 20. 20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐Removal from State Holy Cross Polish National Baltimore, Maryland 2008 4 □ Donation 7 5 □ Other (Specify) Signature of Funeral Service Lice 22 Name and Address of Facility Lome Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ance: letastati yea Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, burial-tran and Due to (or as a consequence of) nding physiclan Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Probably 1 ☐ Yes 2 ☐ No 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy page 1⊟ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 XVo Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 1 ☐ Yes 2 this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After Injury or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: of completely filled in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 056 magain 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 N. CHAPLES ND BALTIMORC. ST. m. D Robert 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March **Physician** 2008 12:30a M John Richard Zavoyna, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. 8, Date of Birth Months Days Hours Min. Matter Day 2 1930 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In vrs. last birthday) **Funeral** 78 Months Days New York 213-28-6551 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐No Baltimore Reisterstown Director Maryland Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Carmelita Ct. 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No 16/18 Ging 52 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛂 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Alcoholic Beverage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked ott any Injury or other traumatic even Be Katherine Zavatsky Michael Zavoyna ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3415 Farmstead Dr. Westminster, MD. 21157 Mary C. Mazzone - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other Complement Evergreen Mem. Gardens March 19,2008 Finksburg, MD. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee . Hath Rellito 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1∐ Yes 2€ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6: ★Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation Injury 1. ■Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician:

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To the Funeral I

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1🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 43725 19, Ridge Road Westminister 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

3/17/08

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			Good Samaritar	Nursing	Center		Baltin				Balt	imore		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birth Month Day May 8 1	<b>ర్మా</b> ర్జ	9. Birth	nplace (State or Foreign untry) CIMORE, MD.	
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	/Medical Examiner		resulting in death)	Due to	(or as a cons	mence of):							One Hould	
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AMIND TIEW/205, perFH, 03/7, 3/19/08, WS
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 14 9:29 A. M March 2008 James M. Adams Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3124 Rices Lane Windsor Mill Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 219-84-8776 MD **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Windsor Mill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 3124 Rices Lane USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Caucasian þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Tow Company Manager Transportation permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 Is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James M. Adams Sr. Diane L. Breeden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3124 Rices Lane, Windsor Mill, MD 21244 Christa Adams/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3-17-08 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory <del>-17</del> <del>-07-</del> Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wile Funeral Tome P.A. of Paltimore Co. 21. Signature of Funeral Service Licensee 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition and the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficiently as the condition are sufficient Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transit or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical the as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has page 2: autopsy performed? 1□ Yes 2X No certificate Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe bow injury occurred After Certification: March 14 2008 929A 1 Natural 5 Pending investigation Gun Shotwound within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No death. 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 (24) RICES LIV Wind Sch Mill MO 21244 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number pleted cause of death (Item 23a) (Type, Print) 3 6 Trimble Hill C. Lutherville, Mdz1053 tel 0 31. Date filed (Month, Day, Year) 32. registrar's Signature, State

Registrar

MAR 1 9

2008

To the Ile

DHMH 17 KeV 1/2001 OCME 2006

Registrar

OCME

Melissa Brassell, MD

MAR 1

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

ORIGINAL

goerle ____

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 16, 2008

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

					Otate of N	iai yiai iu /		ificate of	Death		leg. No.			<u> </u>
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Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Merylend Depertment of Health end Mental Hygiene. Depertment of Health end Mental Hygiene. Important: if item 27 ie marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at DECs.	Completed by Funeral Director	1 Never Marrie		Armed Forces  1 Yes 25  If Yes, Give  Yeer or Dates	F140		Yes, specify Cub ☐ Yes 2 ( )		o Rican, etc.)	Specify	k, White, 6 Wh	ite	
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08-02045 Phyllis Ann Braswell

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2008 08822

,		For State	,,	Certificate	of De	ath			Reg.	No.		
Physician	/ 1	. Decedent's Name (First, Middle,Last)						2. Date Mon	of Death th Da	y Year		ime of Death 0736 hrs
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,	-	. Social Security Number 6. Sex	7 Age (I	n yrs. last birthda		Inder 1 Year	If Under 2	24Hrs. 8. Da	ate of Birth(N	IM/DD/YYYY)	9. Birthpla	ce (State or
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5-0036 lied within 72 hours after death with the Maryland Hygiene. I other than "natural", or items 23a or 28a-f sht the Medical Examiner must be notified at once the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only		duri	ng most of	working life.	DO NOT u	ind of work do ise retired)	one 1	Sb. Kind of Bus	iness/indus	stry
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2121 ould be fill I Mental H i marked ic event,		19a. Informant's Name/Relationship (Typ	e, Print )							r, City or Towr		
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Baltimore, permit. Pages 1 an Department of He Important: If He injury or other tr	Ī	21. Gignature of Funeral Service License	e X		Mare	and Address	H Wes	st	D = 3 + 4		Μ 🗖	21215
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Box 687 e death certific the attending 1 ed for use as th	<u>ici</u>	past 12 months?	4 Pregnant at til		=	(Specify)				1		
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death.  The Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Completed by						15 -41	(Check only o	Yes 2	No 1	<b>✓</b> Yes	2 No
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To To con	ĕ	29b. Signature and title of certifier	and manner stated.			29c. Licens	se number			29d. Date sign		h, Day, Year)
		Dom mui	Limia			O.C.	M.E.			March 14,	2008	
		30. Name and address of person who co				<u> </u>	D-101	140.0	4004			
			Assistant Medica		111 P	enn Street	, Baitim	ore, MD 2	1201	-		
Sta Registi		31. Date filed (Month, Day, Year)  MAR 1 8 200	32 Registrar	s orgnature	DOUBLE.	1						
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10

DHMH 17 Rev 1/2001

State Registrar

KICHAND 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

PITZASON IN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 19 2008

N



**ORIGINAL** 

29c, License number

29d. Date signed (Month, Day, Year)

Greene St Baltimore MD 21201

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			Registrar     Decedent's Name (First, Middle, Last	<i>t</i> )		nimodio oi b		2. Date of Dea	th C	HUU	3. Time	of Death		
	Physicia	an	Ralph Saville		lds, Jr	•		March 7	, 2008	Ye <i>a</i> r	9:09	A. M		
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Death		4c. Count	y of Death	h			
	LAditiiii		3005 S. Leisure Wo	orld Blvd.,	#111	Silver S			Montg					
F	uneral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Cot	hpl <i>a</i> ce <i>(State</i> untry) ng <b>ton,</b>	_		
D	irector		578-34-2166 Usual Residence of Decedent	0	0			June 6,	1921	Wasin	ingcom	D. 0.		
/land	at		10a. State 10b. County 10c. City, Town or Location 10d. Insic											
Man	a-f sh ifled	ţċ	Florida Saraso		10g. Citizen of What Country?									
th the	or 28 e not	Director	10e. Street and Number		,	_								
ath wi	23a ust b	5248 Marshtield Lane 34235  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-								d St	rican Indian,			
er dea	tems ner m	nue	11. Marital Status  12. Was Decedent Ever if U.S. Armed Forces?  15. Was Decedent Ever if U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black								White, etc.			
rs affe	nd Mentral Hyghenta Hyghenta Hyghens 23a or 28a-f show marked other than "natural" or flems 23a or 28a-f show matic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 194	45-1947	1 ☐ Yes 212 No	Specify:		Spec	ify: W	hite			
2-0000 72 hours af	atura cal E	led								Business/	Industry			
hin 7.	an "n Medi	Completed	(Specify only nignest gra	9	Dominio									
With De	er the	S.		22	Chair	rman of the		o (First Middle		nking	5			
Ψ	g U S	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)  Virginia Turner										
Sed Sed	Men narke	۴	Ralph S. Childs, Sr. Virginia											
Mar 12 sh	n and 7 is n traun		19a. Informant's Name/Relationship (			Marshfield								
			Dorothy H. Childs 20a. Method of Disposition	/ WITE		sposition (Name of rematory or other place		Date 13,	20c. Location	ı - City or	Town, State			
ages			1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification )	IRemoval from State	lont comers	Crematorium	20	800	Bethe	sda.	Mary1	and		
IITII	ortan injur		21. Signature of Funeral Service Licer		Diregonary	22. Name and Address Bethesda-Ch	s of Facility Rol	pert_A.	Pumphr	ey Fu	ineral	Home,		
death certificate be executed E S C Department of Health at	any and		Il M. M.		J14/3	Bethesda, M	aryland	20814-3	501	WISC	Onsin	nve		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not	enter the mode of dying	g, such as cardiad	or respiratory a	rrest,		Approxim Interval I Onset ar	Between		
Ph	ysician		Immediate Cause (Final disease or condition			inoma of th					14 Y			
	Medical		resulting in death)	Due to (or as a co										
EX	aminer		Sequentially list conditions,	b	pagamoneo of):							-		
pe	sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
xecut	and al-tran	xan												
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	phys s the	edical	839	- U.										
o h cert	attending physician and for use as the burial-transit	Physician/M	IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								elivery Day	Year		
deat	ne atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tim 9□Unknown		5 Other (specify)				Month	24,			
P.O.	signed by the a Id be detached f	Phys	9 Unknown		ent reculting in th	a undarlying cause dive	en in Part I	23e. Did	tobacco use contribute to the cause of death					
S, res th	signed be de	by	1 □ Ye								es 2X No 3 Probably 4 Unknow			
Division or Vital Records,	been si should I	Completed						24a. Was	an 24	th Were:	autopsy findir	nos availabl		
e law	has b	nple.						auto perf	psy ormed?	prior to death?	completion	of cause of		
a <b>K</b>	certificate ector, pag		25. Was case referred to medical	T			26 Place of De	1  Yes ath (Check only	2K No	1 □ Ye	es 2□No			
/ision or Vita Attending Physician:	n. After this certificate has funeral director, page 2	Be C	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	atient 3 DOA Othe		Home 5□Res		Other (Sp	2nd ecify)Res	idence		
o a	er this	1: To	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Tim	ne of 28c. Injury		28d. Describe						
o sign	rth. r: Afte e fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	, , ,	car/ mja		Yes 2 ☐ No							
ViS	er des recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc. (	<ul> <li>At home, farm 'Specify)</li> </ul>	, street, factory, office		28f. Location City or To	(Street and Nu wn, State)	ımber or F	Rural Route I	Vumber,		
ital or	rs aft ral Di led in	Certification:				In table to a support the above the	me date and also	ond due to the	course(s) one	manner	as stated			
Hospi	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical Exa	hysician: To the best of r	xamination and/	neath occurred at the tire or investigation, in my c	me, aate and plac opinion, death occ	curred at the time	, date and pla	ce, and d	ue to the cau	se(s)		
the	thin 2 the	Medical	one) 29b. Signature and title of Certifier	and manner states	u.	29c. Licens	e number		29d. Date sig	gned (Mo.	nth, Day, Yea	ar)		
P N	T wi		16/1/1	anninata	MY	7   n2	1115		March	7, 2	008			
11	14		30. Name and address of person who	completed cause of deal	th (Item 23a) (Tv	ne Print)								
1	)		Lee R. Pennington	n, M.D., 102	15 Fern	wood Rd.,	#100, Be	thesda,	Maryla	.nd 2	0817-1	183		
	° S	tate	31. Date filed (Month, Day, Year)	32 Registrar's	s Sign <i>a</i> ture	Small !								
	- Ponie	trar	MAD 1 0 2	HUN AND CO.	. 18 1	LONGLAND B								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 2008 00:35AM Edith K. Drewen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Baltimore OWSOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-03-1940 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 ☐ M 2 🔀 F 67 213-36-1110 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 1 and 2 should be filed within 72 nours when 2 should be filed within and Mental Hygiene.
Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other t 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 4230 E. Joppa Rd U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: White Completed by 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dewey Wilson Puffenberger Mary Kathleen Crissma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: if Item 27 is any injury or other trau 393 Watters Rd New Park, PA 17352 Bryan Drewen (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03-21- 2008 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STAPHYLOCOCCUS AUREUS ENDOCARDITIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe certificate 1∐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this 27. Manner of Death
1 Natural
2 Accident funeral 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. spital or Attendi hours after death. Ineral Director: / y filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and the of certific 29c. License number 29d. Dale signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

LOW, M. D 31. Date filed (Month, Day, Year)

MAR 19

7601 OSLER DRIVE TOWSON, MARYLAND

TIMOTHY

2008

32 egistrar's Signature

D24034

			For State Registrar	State of Ivialyla		rtificate of		R	leg. No. 2 ()	8 08826
P	Physicia		1. Decedent's Name (First, Middle, La Camille	rst)	DeFrei	tas		2. Date of Dea Month	Day Yea	3. Time of Death
150	/Medic		4a. Facility Name (If not institution, give	ve street and number)	Derrer		or Location of Death		12, 2008 4c. County of De	10:30P M
	Examin	er	321 University		229		r Spring		Montg	
	Funeral Director		5. Social Security Number 6. S		s. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. B	irthplace (State or Foreign Country)
, Sept.		-	Usual Residence of Decedent					July 4	, 1917   N	ew York
	rylanc how	. [	10a. State 10b. County	10c. C	City, Town or Lo					10d. Inside City Limits
	e Ma Ba-f s	cto		omery		Silver	Spring			1 ☐ Yes 2 X No
	th with the 23a or 2 ist be no	al Dire	10e. Street and Number 321 University	Blvd. West	#229	10f. Zip Code	0901		10g. Citizen of What of United S	·
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wl Specify:	nerican Indian, nite, etc. Black
5-0	72 hc 'natur dical	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occu	pation during most of world)	king	16b. Kind of Busines	ss/Industry
2121	d within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire afeteria			Schools	/ Education
þ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Las					, , ,	Maiden Surname)	
ylaı	ould b Ment arked artic e	10	Ram	DeFreitas	-		Carm		Mescus	
Jar	2 short and raum		19a. Informant's Name/Relationship		1	-			er, City or Town, State	20901
Baltimore, Maryland 21215-0036	1 and Health em 27 ther t		Louis DeFreitas  20a. Method of Disposition	·		Universi osition (Name of ematory or other pla		Date	Silver Sp	
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai		1 ☐ Burial 2 ☑ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	_Internoval from State	hesapea	ake Crema	tory 3/1	7/2008	Beltsvil	le, MD
Ball	permit Depart Import any In		21. Signature of Funeral Service Lice	man Moo3	82 E	2. Name and Addr Rapp Fune 933 Gist	ess of Facility ral and C Ave., Sil	remation ver Spr	n Services ing, MD	20910
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	mplications that caused the de y one cause on each line.  a.  Due to (or as a cons)  Due to (or as a cons)	Anemia equence of):  Abdomic equence of):			or respiratory ar	rrest,	Approximate Interval Between Onset and Death
68760,	Attending Physician: The law requires that the death certificate be executed death.  ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
P.O. Box	t the death cert by the attendinached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf preç 1 □ Live birth 2 □ F 4 □ Pregnant at time c 9 □ Unknown	etal death 3	□Ectopic pregnan □ Other (s <i>pecify)</i> _	cy		23d. Date of Month	delivery Day Year
ds, F	law requires that the de as been signed by the : 2 should be detached	by	Part II. Other significant conditions	contributing to death but not r	resulting in the	underlying cause g	iven in Part I.	23e. Did to		e to the cause of death?  Probably 4 Unknown
Division or Vital Records,	i: The law req cate has beer ; page 2 shou	Completed						24a. Was autor perfo 1 Yes	psy prior prmed? death	autopsy findings available to completion of cause of ?? 'es 2 \Bo
V.	siciar certif	Be	25. Was case referred to medical examiner?	Hospital: 1 Depoties t	□ ED/Outpotic	2 DOA 0	ther:	th (Check only o	/	
on or	ding Phys 1. After this funeral di	ion: To	1  Yes 2  No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year	ER/Outpatie 28b. Time Injury	of 28c. Inj	4 🗆 Idaising i		dence 6 Other (S	ресіту)
Divisi	i Çirli	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be lass of injust A	t home, farm, s ecify)			28f. Location ( City or Tou	Street and Number or wn, State)	Rural Route Number,
_	Hospital 24 hours a Funeral etely filled	Medical C		Physician: To the best of my laminer: On the basis of examand manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Ros	0	29c. Licer	nse number		29d. Date signed (M	onth, Day, Year)
			1	MU	X	DO	0043436		March 1	.4, 2008
	10		30. Name and address of person wh							
	6		Husna R. Baksh	M.D. 10801 I	Lockwoo	d Dr. #28	30, Silver	Spring	, MD 2090	)1
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 9	2008 32 Registrar's Si	I A	0042				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Inf G878 4/02/08 Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Reg. No. 1 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Rose Catherine Davis 30 2008 ile March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Sinai Hospital Cita Baltimore palfimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Numbe 213-62-5763 Date of Birth (Month, Day, Year) 6 Sex Months Days Hours Min. 1 M 20XF MD 10/26/1952 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No N/A Baltimore City MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2016 Whistler Avenue 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2XXIII Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **HOmemaker** Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura V. Brannon Robert Frampton Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2016 Whistler Avenue, Baltimore MD 21230 Tammy C. Day / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 3/21/08 Baltimore MD Bay View Crematory 4 ☐ Donation 5 ☐ Other (Specify) poda, 1. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 al Service Licensee Victor 23a. Part1. Enter the disease, or or the subors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Discase End-stage Chroniz Obstructive Kulmonaw Advanced Emblidsema 20 years Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 1 ☐Live birth 3 □Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

l or Attending Physician: The law requires that the death certificate be executed after death. burial-transit the attending physician and hed for use as the burial-trar Š signed to funeral director, page 2 should peen certificate has After this within 24 hours after death To the Funeral Director: filled in by the

Physician/Medical

ģ

Be Completed

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
in the past 12 months?
9 Unknown

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

	auto perfo 1∐ Yes	psy ormed? 2 No	
n ((	Check only o	one)	

21215

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

-1										
ı	25. Was case referred to medical	26, Place of Death (Check only one)								
	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Injury at Work? 1   Yes 2   No								
	3 Suicide 6 Could not be determined									
	29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								

Lou.	Continuo
	(Check only
	one)
	/

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the , Year)

belieder Bythmore MI)

one)	and manner stated.			
b. Signature and title of certifier		29c. License number	29d. Date signed (M	onth, Day
1 Ocholite	La . MD.	RES 000.	Maria 16	200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 mi West Unicha 31. Date filed (Month, Day, Year) 32. Registrar's Signature



State Registrar

completely

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEN TITM// Oa c. per H1, G3/7, 3/19/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (Eirst, Middle, Last) Month Day Physician 4c. County of Death March 12 nne /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HILTON 57. If Under Months If Under 24 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ▼ F Days Hours Min -82-0628 Director cyland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10b. County r 28a-f show notified at 10a. State 1 Nes 2 No Funeral Director ITimo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 2122 Ton 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 o Baltimore, Maryland 21215-0036 Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) larmac' rmac N 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Audre Nillis ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Drake husbara HILTON thare Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Metro Crematory of other place) Catonsville, 1 Curial 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) -19-08 LUSO MEM 22. Name and Address of Facility 21. Signature Funeral Service License P. March F.H. 12 i 23a. P. 1. Intel 1 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Couse (Final disease or condition resulting in death) OF UNKNOWN ADENOCARCINOMA 14 month Physician /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Sas attending r IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Vear in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 s certificate has autopsy performe Yes 2 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 27. Manner of Leath 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 XNatural 2 ☐ Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D16354 d cause of death (Item 23a) (Type, Print) ク CATON AVE BALTIMORE 900 1 **9** State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per th 9877 3-19-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:45° M **Physician** DZHANASHVILI 2008 03 16 DAVID /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner #307 BALTO. ROAD CITY BALTIMORE FALLSTAFF If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)

1 - 23 - 19 20

REPLIBLIC OF GEORGIA 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. 1 M 2 F Months Days Hours 214-94-4028 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Nes 2 No BALTO. CITY BALTIMORE MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #307 21209 ROAD USA FALLSTAFF 2901 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify Specify: WHITE Baltimore, Maryland 21215-0036 à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ ARCHITECTURE ARCHITECT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DZHANASHVILI BOTERASHVILI RUTH AARON ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RUTH PENN / DAUGHTER 1505 NEAR THICKET LANE, STEVENSON, MD 20b. Place of Disposition (Name of CHEVRA CHARVAS CHESED Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 03/18/2008 | RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Lee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) intarction Myoeardial Physician /Medical Due to (or a a consequence of): 6 years Examiner Coronary artery Securitielly fut conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner andiovascular disease Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 I Inknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 2 ☑ No has 1□ Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) director, Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t (Month, Day Year) Injury 1 M Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 ☐ Homicide within 24 hours a To the Funeral I 1 V ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03/16/08 D29928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 Greene Tree Rd, Ste. 300 Pikesville, MD Zizo8 David J. Penn MD 32. egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 19 Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ewashen Month **Physician** 9.25 Mari 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Date of Birth (Month, Day, Year) OV. 19,1913 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 7 F 94 Nov. Director 215-22-5343 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ns 23a 8202 Kramer Court Apt. 3-B 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? "natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 X No ģ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Julius Swartz Elizabeth Truetle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8202 Kramer Court Apt. 3-B Glen Burnie, Maryland 21061 John Ewashen (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o Department of 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Green Mount Crematory 3-18-08 Baltimore, Maryland 21212 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying causes that initiated events resulting in death) Last Examiner death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the. 38 IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown for Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign 1 Tes 2 No 3 Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 200 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division or Vital Records, P.O.

3altimore, Maryland 21215-00

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

BIVA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loch Kaven

Ballineerle, Kd-

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 9 2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g87/ 3-28-08 vt.
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** E. FOWLER SARAH 14.March 2008 8:20 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner 1005 Fieldstone Place Orchard Beach Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Both (Month, Bay, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 1 F Director 216-20-2675 90 Aug. 27, 1917 Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Items 23a or 28a-f shov ner must be notifled at 1 ☐ Yes 2 No Beach Orchard Anne Arundel Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21226 1005 Fieldstone Place by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 'natural", or White 3altimore, Maryland 21215-0036 Specify: Specify. 3 Widowed 4 □ Divorced Year or Dates Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ô Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ellen Brophy Samuel Lamont မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Fieldstone Place, Baltimore, Maryland 21226 Nancy A. Disney (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If Ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 03-18-08 Brooklyn Park, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Immediate Cause (Final squamous cell cancer of skin. Metastatic zyears Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760分 attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a, Was an autopsvi performed? res 2 No After this certificate 1☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient ۴ 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury death. 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: / 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of entitier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and add atomare Baltimore MD 21229

Registrar DHMH 17 Rev 1/2001

State

anoles 31. Date filed (Month, Day, Year)

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32 Registrar's Signature

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per md 2877 3-18-08 Yand Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25 TM Robert H. Frickel 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1+1More Square Hospita osedale ranklin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 01/19/1926 Colorado 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours 515-20-4691 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at Harford Bel Air 1 ☐ Yes 2 No MD. Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21014 1405 Harvard Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Elementary/Secondary (0-12) College (1-4or 5+) 5+ Government Physicist Department of Health and Mental Hyg Importment of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event. # Once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Genevieve Ingram Henry Frickel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1405 Harvard Ct. Bel Air, MD. 21014 Gloria Frickel/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 20c. Location - City or Town, State Date 20a. Method of Disposition 03/18/08 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
Evans Funeral Prive Forest Hill, MD. 21050 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill, MD. 3a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirok, or heart failure. List only one cause on each line. Immed te Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical **Examiner** Drasete Sequentially list conditions, if any, leading to immediate cause. Enter Universific Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Diseans Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has breeter, page 2 s autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 X Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOAIB A HASHMI SIN EUTAN ST Swite 308, BALTIMORE MY

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

P.0.

Division or Vital Records,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM/20b. per FH C877. 3/21/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 15, William Washington Glass 2008 8:08 P. M March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 304 Edmonston Drive Rockville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Montgomery 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 85 Director 217-16-0010 Dec. Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Menta Hygiene.
ntt: If item 27 is marked other than "natural;" or items 23a or 28a-f show 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 TXYes 2 □ No Director Maryland | Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Edmonston Drive 20851 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 1 0 / 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No þ Specify Specify: White Year or Dates: 1941-74 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) Naval Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Booker Glass Pearlie Inez Keesee 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgina E. Glass / Daughter 1 Lakeview Dr., N.E., Iowa City, Iowa 52240 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 10, 2008 permit. Page:
Department of
Important: If i
any Injury or
once. ò 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery March 20, 2008 - Arlington, Virginia 21. Signature of Funeral Servi Röbert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the dise shock, or head failur Immediate Cause (Final **Physician** Coronary Artery Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of) as the burial-Division or Vital Records, P.O. Box 68760 the attending physician The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I Yes 2 □ No 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Hyperlipidemia 1 Tes 2 No 3 TProbably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy performed? Yes 2. ☑ No To the Hospital or Attending Physician: within 24 hours after death.

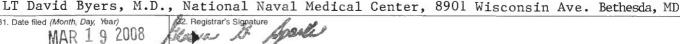
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 Pending investigation 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

mx,

State Registrar

MAR 1 9 2008

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VA 0101246594

7MAR 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend #27 Per ME G878 4/14/98 rtifficate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 8:15 PM 12 2008 Myrna Eileen Hrubec 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Rosedale Sougre Hospital Center FRANKLIN Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Hours 1 M 2 F Months Days 204.22.5339 79 Mar.8,1929 PA Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 10 Parkville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21234 8800 Walther Blvd. Apt. 3605 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 500 If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Matter Raymond Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type. Print) 8800 Walther Blvd. Apr. 3605 Parkville. Zdenek Hrubec/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Deake Crem. 03.14.08 Beltsville, MD 22. Name and Address of Facilit CAFA/Stephen D. Lohrmann, PA Chesapeake Crem. 21. Signature of Funeral Service Licensee M01442 Butter 8717 Green Pastures Dr. Balto., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Subdural Hematoma Due to (or as a consequence of): Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 9□Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Highblood 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an osteoporosis autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1-1-1-tural 2-1-1-tural 2-1-1-tural 5 Pending investigation Fell 111/2008 1 ☐ Yes 2 ¥ No Subject UNK 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide

Examiner Division or Vital Records, P.O. Box 68760, attending ph certificate After this the Funeral Director: Aff

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

MD

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any blury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

MYKN

Saltimore, Maryland 21215-0036

Hra

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death

> 28f. Location (Street and Number or Rural Route Number, City or Town, State)
> 8800 Walther Blvd., MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier

NUISING

29d. Date signed (Month, Day, Year) -2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 FRANKLIN SQUARE DR Balto md Dr Stephen R. Selinger 31. Date filed (Month, Day, Year)

Home

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Bepartment of Realth and Mental Hygiene Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last)

A A A Mohammed 2. Date of Death Hussain Year **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner U MUERSITY OF MASICAL mercans MENTER BALTIMOLE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02 16 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 215-78-7573 39 India Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar process. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Director Belair Harford MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 935 Jackson Blvd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 4yrs Self Employed 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Badarunnisa Begum Mohammed Iftekhar Hussain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7503 Spring Lake Drive, Bethesda, Md 20817 19a. Informant's Name/Relationship (Type. Print) Mohammed Hussain-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3/16/08 Randallstown, Md 21. Signature of Funeral Service Licensee Marchand Adress West 4300 Wabash Ave, Baltimore, md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hem failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (OCARDIAL INFORCTION, RIGHT SIDE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ned by the attending physician ank detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9☐Unknown certificate has been signed I rector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 28 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 → No 24a. Was an autopsy performed? Yes 2 LNo the Hospital or Attending Physician: the funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation М 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 South Greenost 32. P 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner Kingsway 8. Date of Birth (Month, Day, Year) rs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 □ Y 2 □ No Funeral Director MD altimore 10g. Citizen of What Country? 10e. Street and Number ō 2/12/8

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 23a Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 or 1 ☐ Yes 2 ☐ No Specify þ 3 N widowed 4 □ Divorced Blac "naturai" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than ondaty (0-12) College (1-4or 5+) and Mental Hygiene. Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Department of Health ar Important: If Item 27 is any injury or other trau once. BNOMD21239 h E 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22/2008 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** da neumon /Medical Due to (or as a consequence of) **Examiner** net allo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21 ☐ Mo P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BAN MD 2122)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me 98795-6-08 vt. State of Maryland / Department of Health and Mental Hygiene A A For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 12:23 p^M 12, Hales 2008 Η. March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 □ M 21€ F 84 Vrs North Carolina 09/06/1923 Director 579-28-1423 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State th and Mental Hygiene. ?? Is marked other than "netural", or items 23s or 28s-1 show traumatic event, the Musical Examinar must be notified at 1 ☑ Yes 2 ☐ No DC Washington, DC Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 20011 825 Emerson St. NW Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: if Item 27 is marked other then "natural", or Items 23s by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Civil Service Worker 2yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown IInknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) B25 Emerson St. NW, Washington, DC Lonnie E. Jackson/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lingoln Memorial Cem. 03/17/2008 Suitland, Maryland 5 permit. Page Department of important: if any injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature Funer Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Listonly one cause on each line. Immediate Cause (Final Respiratory Failure Paysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CERTIFICATION AFPROVED BY MEDICAL EXPANSIVE Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit ding physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Dav atten Month jo in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the ail do be detached for Tyes 2 1 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Hypertension 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed need 24b. Were autopsy findings available prior to completion of cause of death? Chronic Kidney Disease 24a. Was an autopsy performed? Yes 2 🛣 No this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 1 XYes 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After Hospital or Attanding 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a Funaral L 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and hite of certifier March 14, 2008 D28656 diress of person who completed cause of death (Item 23a) (Type, Print) 20850 Dr. Ravi Passi, MD. 15225 Shady Grove Rd, #208, Rockville, MD 32 Aegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>008</u> **Physician** March 17, 7:20 AM William C. Hainsworth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1729 Urby Drive Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □XM 2 □ F 045-16-2746 82 Dec. 8, 1925 Connecticut Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits f show a or 28a-f show t be notified at 1 XYes 2 ☐ No Director Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b USA 1729 Urby Drive 21114 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Ongin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give 1944 Year or Dates: 1947 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: Specify. þ 3 Widowed 4 Divorced White "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Government and Mental Hygie traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milford Hainsworth Linda Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Ellen Hainsworth/ Wife 1729 Urby Drive Crofton, MD 21114 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages permit, Pages
Department of I
Important: If Ite
any injury or o
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan 4 ☐ Donation 5 ☐ Other (Specify) 3/18/2008 Alexandria, VA 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cessivalons /Medical Due (or as a consequence of): Examiner ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o Examine be executed bunial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2No 3 Probably 4 Unknown DISEASE 1 ☐ Yes Completed RHEUMATOID ARTHRITIS. 24a. Was an Were autopsy findings available prior to completion of cause of perform 2X No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25134 3-18-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Carol A Pressey. M. D. 3169 Braverton Street #101 Edgewater, MD21037 32. Registrar's Signature

DHMH 17 Rev 1/2001

08-02066 John W. Hebb Please Type or Print in Black Indelible Ink. Ensure A State of Maryland / Department of Health and M

All Copies Are Legible. Mental Hygiene	200	8 088	3 + 0
Reg. No.			
2. Date of Death		3. Time of Death	

		- For State Registrar	_		Certifica	ate of	Death			Reg	ı. No.			
Physicia	n/	<ol> <li>Decedent's Name (First, Middle,</li> </ol>					·			Date of Death Month	Day	Year	3. Time of Death	
Medical Examin		John Wallad					· · · · · · · · · · · · · · · · · · ·		V	March 14, 2	2008		0248 hrs	
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Funeral		,	. Sex	7. Age (Ir	yrs. last birth	iday)	If Under 1 Ye			B. Date of Birth	(MM/DD/)		Birthplace (State or Foreign Country)	
Director			X M 2 F		80	Yrs.	Months Da	ys Hours	Min.	March	23,19		hio	
any	-	Usual Residence of Decedent  10a. State 10b. County		100	: City, Town o	or Location	on						10d. Inside City Limits	
≥	۱	Maryland Prince	George	's	Bow	ie				1 XXYes 2 No				
th the Maryland 23a or 28a-f sho notified at once.	ōΙ	10e. Street and Number					10f. Zip Code			10g. Citizen of What Country?				
h the l 3a or		12513 Brewster 1	Lane				20715				US	SA .		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmitic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 X Marr		Forces?			Decedent of H es, specify Cuba					Race - Am White, etc	nerican Indian, Black, 	
after all, o		3 Widowed 4 Divor	ced If Yes, Give Y			1	Yes 2 X N	o specify:			Spe	cify:	White	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours afte nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	Completed by	15. Decedent's Education (Specif	y only highest g	rade comple	ted) 16a. D	ecedent uring mo	's Usual Occupa est of working life	ation (Give I e. DO NOT	kind of work use retired	k done )	16b. Kind	of Busines	ss/Industry	
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215 e file tal Hy ked o	a. I	Roy Albert Hebb	,							chello		,		
2121 ould be fill J Mental F s marked ic event,		19a. Informant's Name/Relationship	(Type, Print)		19b	. Mailing	Address (Stre					Town, St	ate, Zip Code)	
MD d 2 shc lth and n 27 is aumati	L	Alice M. Hebb /	WIFE		1	2513	Brewst	er La			MD 20	715		
rre, s 1 and f Heal If iten		20a. Method of Disposition  1 Burial 2 XCremation	3 Remova	I from State			tion (Name of co er place)	emetery,	C	Date	20c. Loca	tion - City	or Town, State	
Imo Page ment o tant:	- 1	4 Donation 5 Other Spec			Metrop	olit	an Crem	atory	3/16	/2008	A1exa	ndri	a, Virginia	
Baltimore bernit. Pages 1: Department of H. Important: If it injury or other t	Ī	21. Signature of Funeral Service &	cersee			22. N	ame and Addres	ss of Facility	Robe	rt E.	Evans	Fun	eral Home	
	1	23a. Part I. Enter the disease, or co	Januariana dha	1 00 10 0 d 10 0	death Dane								and 20715 Approximate Interval	
Physician /Medical	1	failure. List only one cause or	each line.								SI, SHOCK,	or neart	Between Onset and Death	
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760, ficate be of g physicia the buria	Š.	IF FEMALE: 3b. Was decedent pregnant in the	23c. If ye	s, outcome o	of pregnancy							ate of deliv		
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al R	Be C	25. Was case referred to medical					26.Plac	ce of Death	(Check onl	y one)				
Vit.	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient		ıtpatient		Other 4	Nursing H				ther: Scene	
Division of Vital Records, P.O. Box 68 rate or Attending Physician: The law requires that the death certificat shallor death.  at Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Certification:	27. Manner of Death  1 Natural 5 Pendin		ite of Injury nth, Day,Year)	28b. T	ime of Ir		jury at Work Yes 2	.	Bd. Describe h	ow injury o	occurred		
r Atte r Atte ler des irecto n by th	ig	2 Accident Investig	28e PI	ace of Injury	- At home, fa	rm, stree	t, factory, office	building, et	tc. 28			Number or	Rural Route Number, City	
DIVI Hospital or / 24 hours after Funeral Dire	틽	4 Homicide determ		fy)						or Town, St	tate)			
	Medical	29a. Certifier 1 Certifying Phy one) 2 Medical Exami		is of examina										
126	ĕ -	29b. Signature and title of certifier	and manne	r stated.			29c. Licer	nse number	DOME		29d. Date	e signed (	(Month, Day, Year)	
ofen.	~	That M1.	1/0/	ורד			0.0	.M.E.	OCME		March	14, 200	)8	
1/4	ŀ	30. Name and address of person w	ho completed ca	ause of deat	h (Item 23a)						L			
1	- 1	Theodore M King Ir I	иD. Assis	stant Med	ical Exami	ner	111 Penn S	treet, Ba	Itimore,	MD 21201				
Sta Registr	te ar	31. Date filed (Month, Day, Year)	2008 32.	Régistrar's	Signature	STOR	and the same							
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Maryla	and / Depa <i>Ce</i>		nt of H <i>te of L</i>			ental Hy	giene Reg. No		0 03	100
4.	Physici	an	1. Decedent's Name	e (First, Middle,	Last)							2. Date of De		Year	1	of Death
	/Medic	al	HARRY  4a. Facility Name (If	THOMAS			₹.	4h City	, Town, or	Location	of Death	March	17,	2008 County of Dea		5 a M
	Examin	er	Laurel Re						ırel	Location	OI Deati		1	Prince		s
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ather than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at		5. Social Security N		Sex 1□M 2□F		vrs. last birthday)	If Unde Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year	9. Bir	thplace (State	e or Foreign
L			213-28-47 Usual Residence of		1∏M 2□F	7	77 Yrs.					Nov. 1	9, 1	.930 Ma	ryland	
			10a. State	10b. County		10c.	City, Town or Lo	cation							10d. Inside	
	he Ma Ba-f s	ecto	Maryland		George'	S	Laurel									es 27No
	72 hours after death with the Marylar "natural", or items 23a or 28a-f show edical Examiner must be notified at	Funeral Director	10e. Street and Nun 16204 Dor		đ				p Code 20707				-	itizen of What C	ountry?	
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36	or ite	<b>by</b> Fu	1 ☐ Never Marri 3 ☐ Widowed			2 No 1	.948	1 ☐ Yes		Specify:		riioan, oto.)		Specific	White	
9	2 hour atural cal Ex	ted k		15 Decedent's	Education	_	.952     16a. Dece	dent's Usu	ual Occupa	ation			16b. F	Kind of Business		
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lary	2 shou and N is mar aumat		19a. Informant's Na				1	ng Addres	s (Street a	and Numb	er or Rura	l Route Numb	er, City	or Town, State,	Zip Code)	
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Baltimore, Maryland 21215-0036	permit. Pages 'Department of P Important: If ite any Injury or of		21. Signature of Fo				Ivy Hil					Home, ]		urel, M	aryrand	<u>.                                    </u>
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			23a. Part1. Enter the shock, or head Immediate Cause (I		omplications that					g, such as	s cardiac c	r respiratory a	arrest,		Approxim Interval B Onset an	etween
	Physician /Medical		disease or condition resulting in death)	n	_a		e Heart	Fail	ure							
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	ertifica ding ph	/Med	IF FEMALE:		7.	to a man and a man										
Вох	death certifi attending I for use as	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐	months?		birth 2 I f nant at time	etal death 3	∃Ectopic p ∃ Other (s	regnancy				23d. Date of delivery  Month Day Year			
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> >	Physic this ceral direct	2	examiner? 1 ☐ Yes 2 🔀		-		2 ☐ ER/Outpatier			4 □ NI	ursing Hor	me 5□Res	idence	6 □Other (Spe	ecify)	
ou c	dlng P	ion:	27. Manner of Death  1 X Matural	5 Pending		of Injury oth, Day Year	r) 28b. Time o Injury	f H	28c. Injury Work	at ? ∕es 2□		28d. Describe	how inju	ary occurred		
Division	Attending Physician: r death. ector: After this certific. by the funeral director.	ficat	2 Accident 3 Suicide	investigat 6 Could not determine	be 28e. Place	e of injury - A	t home, farm, str			res Z		28f. Location (	Street a	nd Number or R	ural Route No	umber,
Ö	tal or safter al Dire	Certification:	4 Homicide		build	ing, etc. (Sp	ecity)	_				City or To	wn, Stat	te)		
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	one) 29b. Signature and	177	and mar	ner stated.			c. License					ate signed (Mon		
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	Sta		Shahab Bay 31. Date filed (Mont				e Patuxe	ent P	arkwa	y, S	uite	200, 0	Colu	mbia, Ma	ryland	i E
	ા Registr		M	AR 192	2008	Registrar's Si	N 60	aske)								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** VELINE 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months 219-12-5088 83 Director 01/28/1925 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3619 SEVEN MILE LANE 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛣 No Specify þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS SHANE IDA ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRAN MITNICK / DAUGHTER 2405 DIANA ROAD, BALTIMORE, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BNAI ISRAEL CONG 03/18/2008 | BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature Juneral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) thrombosis **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit and Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð page 2 should be 2 **N**o 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Sp. 1975) Hospital: 2 No Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death e Funeral Director; 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed

Physician:

Hospital or Attending

Division or Vital Records, P.O. Box 68760

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

29a. Certifier

	one)	MI Wedic
29	b. Signatur an	d title of certif
	<b>▶</b> / 79	1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

of person who completed cause of death (Item 23a) (Type, Print)

2008

29d. Date signed (Month, Day, Year) 2008 old Courd Ro

State Registrar

completely

within 2 To the

31. Date filed (Month, Day, Year) MAR 1 9

BOBMO 32 Registrar's Signature

Levetle Johnson

UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 08843

CUNK		1-For State Of Maryland / Department of Fleat  Certificate of Dea	th			
		Registrar		Reg. No. 2. Date of Death		3. Time of Death
Physicia	an/	Decedent's Name (First, Middle,Last)		Month Day March 9, 2008	Year	1552 hrs
al Exami	ner	Levette Johnson	Town, or Location of Death		c. County of Deat	<u> </u>
		4a. Facility Name (if not institution, give street and its insert)	more	1	o. 000m,	
		University Hospital		8. Date of Birth (MM	UDDAVVVI a Bi	rthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	der 1 Year If Under 24Hrs. ths Days Hours Min.	7	Forei	gn
Director		220.82.1020 1 SM 2 F 35 Yrs.	ans Edys Hours I want	10.11.1	972	ountry) MD
		Usual Residence of Decedent				10d. Inside City Limits
ny .		10a. State 10b. County 10c. City, Town or Location				1 Yes 2 No
L DOW		MD Frederick Frederic	ck			
ylan a-f sł t onc	cto	10e. Street and Number	ip Code	10g. Ci	tizen of What Co	untry?
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	Director	810 B Heather Ridge Drive 21	1702	U	.S.A.	
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r dea or it	[ 큔	Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes	2 No specify:		Specify: <b>BL</b>	
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36 n 72 nan ' licat	be	Self Em	ploved	II	iome kei	nodeling
5-0036 iled within 7. Hygiene. I other than	팀	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maide	en Surname)	
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re, MD s 1 and 2 sho of Health and If item 27 is		20b. Place of Disposition	value of confectory,	Date 20	c. Location - City	or Town, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Montal Hygiene.  I main of Health and Montal Hygiene.  The main I file and 21 is marked other than "natural", or items 23a or 28a-f sho and 11 file and 21 is marked other than "natural".		2 Cremation 3 Removal from State crematory or other pla		3.17.08 E	Roltevi	11 ₀ MD
Page nent ant:	П	4 Donation 5 Other Specify: Chesapeake	and Address of Facility CA			
Baltimore, MC permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other trauma		21 Signature of Funeral Service Licensee CONYS 22. Name a	8717 Green	ra Stepi	ieli D.	Balto MD
00 % A E E		23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the mo	de of dving, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval
, Physician		failure. List only one cause on each line.	30 0. o/g,			Between Onset and Death
Medica amine		Immediate Cause (Final disease a. Multiple Gunshot Wounds				
allille		or condition resulting in death)  Due to (or as a consequence of):				
	١.	Sequentially list conditions,  if any leading to immediate  Due to (or as a consequence of):				
	Examiner	if any, leading to immediate  Due to (or as a consequence or):  Cause. Enter Underlying Cause				
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60, ate be ex hysician	3	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli Month	very Day Year
Sox 6876 leath certificate e attending phy for use as the	2 2	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal de		nancy	, worth	22,
th ce	En .	4 Pregnant at time of death 5 Other (	(Specify)			
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requ	nous	Completed		autopsy perform		r to completion of cause of th?
e law	٧ .	<u> </u>		1 <b>✓</b> Yes 2		Yes 2 No
tal Rec sian: The certificate			26.Place of Death (Che	ck only one)		
ital	i ject	m examiner? Hospital: Inpatient 2 FR/Outpatient 3	DOA Other Nur			Other:
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r ding	e tru	To Natural 5 Pending Mar 9, 2008 1523 hrs	1 Yes 2 ✔ No			
Sio Atten deat	ğ.	2 Accident Investigation 28e. Place of Injury - At home, farm, street, fa	actory, office building, etc.	28f. Location (Str	reet and Number	or Rural Route Number, City
I or z	= :	determined L (Specify) Local Street		or Town, Sta 700 Block of W	ildwood Road,	Baltimore, MD
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director:			at the time, date and place,	and due to the cause	(s) and manner as	s stated.
n 24 re Fu	completely	one) and Medical Examiner: On the basis of examination and/or investigation,	in my opinion, death occurre	ed at the time, date ar	nd place, and due	to the cause(s)
To th	com	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed	(Month, Day, Year)
		296. Signature and the of certifier	O.C.M.E. 00	OME	March 10, 20	008
		Theodore Ul. They & TM, sun				
9		30. Name and address of person who completed calls of death (hem 23a)	1 Penn Street, Baltim	ore, MD 21201		
1		Meddore W. King, St., W.B. Addition to the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	1 7 CHH GUCCL Daith	,		
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	Sta	ate 31. Date filed (Month, Day Year) 32. Registrar's Signature				
Reg	Sta	ate MAD 1 6 7RNS AVE AVE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month March 13, 23:06 John Delano Jackson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 1**X** M 2 □ F Yrs 1936 71 14, Vista, Md. Nov. 577-50-1295 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Maryland | Prince George's Temple Hills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 20748 4417 23rd Place 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 ▼ Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Aircraft Mechanic 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosa Hackley John Edward Jackson
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4417 23rd Place Temple Hills, Maryland 20748 <u> Arlene M. Jackson / Spouse</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran's 3/20/2008 Cheltenham, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications if all caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Priknown . Were autopsy findings available prior to completion of eause of death?
1 □ Yes 2 □ No 24a Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, for

Examine

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

"natural", or items 23a or 28a-f show direal Examiner must be notified at

of Health and Mental Hygie If item 27 is marked other or other traumatic event, tt

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

page 2 director,

Physician/Medical

þ

Completed

Be (

Certification: To

Medical

29a. Certifier

Hospital or Attending Physician: this after death filled in by within 24 hours completely

State Registrar 1 Natural 2 Accident

3 Suicide 4 ☐ Homicide

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 3/16/2008

RAHIMIAN, 31. Date filed (Month, Day, Year) MAR 9

29b. Signature and title of certifier

10403 MD 32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 12:45 PM 2008 March LYON 15 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death Hopkins Bayview Medical Genter Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 213-28-366 19 11930 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Baltimore n/a 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code USA 21215 3717 Bartwood Road 12. Was Decedent Ever in U.S. Armed Forces? A Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married African-American 1 ☐ Yes 2 No Specify 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore City College (1-4or 5+) Engineer Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lottie Foster Taris Hunt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3717 Bartwood Road, Baltimore, MD 21215 Debbie Jennings/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Buria! 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 3-26-08 Garrison Forest Veterans 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Sign dure of Funeral Service License 9200 Liberty Rd., Randallstown, MD 21133 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrnythmia Due to (or as roonsequence of): 5 minutes Stage Renal Disease 6 weeks End Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

"natural", or items

Medicai

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Pages 1 and 2 should be filed wi fment of Heath and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the

permit. Pages Department of Important: If it any injury or or

Funeral Director

Completed by

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Examiner

Physician/Medical

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Be

1 ☐ Yes 2 No

27. Manper of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

MD.

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Saltimore,

Box 68760,

P.O.

Division or Vital Records,

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Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur the ျ

Medical Certification: To

State

Registrar

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RES-000

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

March 15,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

4940 Eastern Evenue Baltimure, MD Ashleigh M.D.

31. Date filed (Month, Day, Year) MAR 1 9 2008 32. Pegistrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

		Plea	ase Type or Pri							gible.	
	4	For State Registrar	State of W	larylaric		artment of I <i>rtificate of</i>		менан пу	giene Reg. No. 2	108	08847
Physicia		Decedent's Name (First, Midd	lle, Last)					2. Date of De Month	eath Day	Year	3. Time of Death
/Medica	ai .	Virginia Anna				I a =		3	18 2	8008	0615 AM
Examine	71	4a. Facility Name (If not institution FRANKLIN SQUO		,	1720		or Location of Deat こんなして	tn		LTIM	064
Funeral		5. Social Security Number	6. Sex 7. A	age (In yrs. la		If Under 1 Year	If Under 24 Hrs		th	9. Birthpl	lace (State or Foreign
Director		215-16-6892	1 □ M 2 💢 F	85	Yrs.	Months Days	Hours Min.	10-30-	1922	Mary	land
and ow	-	Usual Residence of Decedent  10a. State 10b. Count	<i>y</i>	10c. City	, Town or L	ocation				10	0d. Inside City Limits
Mary I-f sho	ţ	Maryland Bal	timore	R	oseda:	le					1 □ Yes 2X No
th the or 282 e noti	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Coun	try?
23a ust b	<u>la</u>	6208 Scranton	Rd			21237			U.S.A		
er dek Items ner m	Funeral	11. Marital Status	12. Was Deceder Armed Forces	?	S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Orlgin? (S oan, Mexican, Pue	Specify Yes or Norto Rican, etc.)	D- 14. FI	Race - America Black, White, o	
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72 hou	ted	15. Decede	nt's Education est grade completed)		16a. Dece	edent's Usual Occu	pation during most of we	orkina	16b. Kind of	Business/Ind	lustry
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filed v Hygie other t	ပ္ပို	17. Father's Name (First, Middle	, Last)		110 02 0		18. Mother's Na	me (First, Middle			
lid be fental rked o	To Be	Harvey Bensel					Elsie (	Unknown)	)		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relation	ship (Type. Print)			ing Address (Stree					Code)
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hysici his ce I direc	일	examiner? 1 Yes 2 No	Hospital: 1 Inpa	itient 2	ER/Outpatie	DIN OLI BOA		Home 5□ Res	sidence 6 🗆	Other (Specif	<i>(y)</i>
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Attenc death cctor: y the	ficat	3 ☐ Suicide 6 ☐ Coul	minod 206. Flace UI	injury - At ho	me, farm, s	treet, factory, office	Yes 2 No	28f. Location	(Street and Nu	ımber or Rura	al Route Number,
al or / s after al Dire	Certification:	4 ☐ Homicide deter	building,	etc. (Specify	V)			City or To	own, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be exitinin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medical	ring Physician: To the be al Examiner: On the basis and manner	of examinat	wledge, dea tion and/or	ath occurred at the investigation, in my	time, date and pla- opinion, death oc	ce, and due to the	e cause(s) and e, date and pla	I manner as s ce, and due t	tated. o the cause(s)
To the within To the compl	Me	29b. Signature and title of certif				29c. Lice	nse number		29d. Date sig	gned (Month,	Day, Year)
		Mutt	my			RES	,0000		3/	8/08	

State Registrar DR matthew

31. Date filed (Month, Day, Year) MAR 1 9 2008

DHMH 17 Rev 1/2001

R. REETZ 9000 FRANKLIN SQUARE DR Balto md 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 🖰

Physician
/Medical
Examiner

**Funeral** 

Director filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

The law requires that the death certificate be executed as the burial-transi A Pu nse detached for the has page 2 certificate or Attending Physician:

Division or Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Fo the Hospital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O3 16 Odell Ezarick Key 2008 12:15a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Woodlawn 2117 Northland Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2□ F 10 215-40-8603 MD 67 04 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 🎇 No Funeral Director Baltimore Woodlawn MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 2117 Northland Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☑ No Specify: Black Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Rhode Island Elementary/Secondary (0-12) College (1-4or 5+) Correctional Dept. of Corrections 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph E. Key Gladys Brockington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 2117 Northland Road, Baltimore, Md <u>Georgette Key-Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation Metro Crematory Inc 3/22/08 Baltimore, Md 21. Signatur of Juneral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pax1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, scock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impordiate Cause (Final Sease or condition resulting in death) Hearl hours Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■ Unknown Completed Cancer Neck 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 🔳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 03-18-2008 29b. Signature and title of certifier 29c. License number 0062164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21201 22. S. Greene MADER N. ITANNA 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of H rtificate of L		and M	lental Hy	giene,	/	3	0884	9
	Physicia	an .	1. Decedent's Name (First, Middle, L.	ast)			-			2. Date of De Month	ath Day	Yea		3. Time of Death	_
	/Medic		Mary Madeline Ha	crison Kin	g					March 1		008		8:03am	1
	Examin	er	4a. Facility Name (If not institution, gi		)		4b. City, Town, or	Location	of Death		4c. (	County of De	ath		
		6	Laurel Regional 1				Laure					ince G			
	Funeral			Sex 7. Ag 1 ☐ M 22 <b>X</b> F	ge (In yrs. la	st birthday) Yrs.	If Under 1 Year  Months Days	If Under Hours	Min.	8. Date of Bir (Month, D	th ay, Year)	(	Country	e (State or Foreig	n
	Director		Usual Residence of Decedent		85	115.				May 20	, 192	2 Vii	gin	ia	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d.	Inside City Limits	3
	Mary Frsh	tor	Maryland Mantage		D.									Y⊆Yes 2 No	)
	r 28a	Directo	Maryland   Montgom 10e. Street and Number	ery	Ь	urcons	sville 10f. Zip Code			1	10g. Citiz	en of What (	Country	?	_
	h with		14744 McKnew Road	1			20	886			Unite	ed Sta	tes		
	within 72 hours after death with the Maryland glen. I than "natural", or items 23a or 28a-f show It e Madical Exambrar must be notified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13.	Was Decedent of Hi f Yes, specify Cuba		igin? (Spe			4. Race - An	nerican		
٥	after or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X			ryes, speciny Cuba 1 ⊡Yes 2X⊡No	in, Mexicar Specify:		Hican, etc.)		Black, Wh	ite, etc.		
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7	72 h "natu	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Deced (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during mos	t of workir	ng	16b. Kin	d of Busines	s/Indus	try	
7	vithin	ш	Elementary/Secondary (0-12)	College (1-4or s	5+)	life. L		)							
· V	7 0 -		10 17. Father's Name (First, Middle, Las	4)			Aide	10.11.11	4- 11	/Fire 4 4 8 st - 4 1		te Em	ьтох	ree	
	ould be fi Mental H arked of atic eve	Be	17. Father's Name (First, Middle, Las	1)				18. Mothe	ers Name	(First, Middle	, maiden s	surname)			
Ž	ges 1 and 2 should be filed it of Health and Mental Hy, If item 27 is marked othe or other traumatic event,	ပ	John W. Harrison	(Time Drink)		405 14-10		Louis			0::				
Ma	nd 2 sl alth an 27 is n		19a. Informant's Name/Relationship				ng Address (Street a						, Zip Co	ode)	
ď	1 and Health em 27 Ither to		John R. Harrison 20a. Method of Disposition	Sr. / Son	20h Pla		4 McKnew			el, Md		0886 _ ation - City o	r Tour	Stato	
saltimore,	ages nt of t: If it		1⊠ Burial 2 ☐ Cremation 3	Removal from State	1		sition (Name of natory or other place	- 1							
	it. P.		4 □ Donation 5 □ Other (Spec		Wilk		Memorial		3/21	/2008	Peter	sburg	, Va		
n n	permit. Pages 1 an Department of Hea Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lice	naere A/	101000		. Name and Addres								
			220 Part Char the disease	wy	ivius J		538 Marlb					, Md.			
	- 3		23a. Part 1. Enter the disease, a conshock, or heart failure. I st only	one cause on each li	d the death. ine.	Do not ente	er the mode of dyin	g, such as	cardiac o	r respiratory a	rrest,		In	pproximate terval Between nset and Death	
1	hysician		Immediate Cause (Final disease or condition resulting in death)	a. INTRA	CRANI	AL HI	EMORRHAGE	2.1						nisci and Scath	
1	/Medical Examiner	ľ	resoning in death)	Due to (or as	a conseque	ence of):									
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,	rted nsit	nin	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the	540 to (or as	a conseque	nice ory.									
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POX	certi nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	су						3d. Date of d	olis sors		
מ	atte	cial	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal of	death 3□	Ectopic pregnancy Other (specify)	/			4	Month	Da	ay Year	
:	the c y the iched	ysi	1 ☐ Yes 2  No 9 ☐ Unknown	9 Unknown											
Τ.	that ned b		Part II. Other significant conditions	contributing to death b	out not result	ing in the ur	nderlying cause give	en in Part I.		23e. Did	obacco us	e contribute	to the	cause of death?	
Records,	jurres n sign ild be	d by	CORONARY ARTERY	DISEASE						1 🗆	Yes 2	] No 3 🗍	Probabi	ly 4🛣 Unknowr	n
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ב ב	ne la e has	m d								auto		prior to death	o comp	letion of cause of	7
VII a	ifficat or, pa		25. Was case referred to medical	<u> </u>						1 □ Yes	2X No		es 21	No	
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5	r rhis	<u>د</u>	27. Manner of Death	28a. Date of Inju		8b. Time of	t 3 DOA Oline 28c. Injury Work	4 LI NU		ne 5 Resi			ecify)		_
5	th. th. fund	Ē	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		ay, Year)	Injury		? Yes 2 □ I			now injury	occurred			
VISION OF	Atter	Certification:	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Inj	ury - At hor	ne, farm, stre	eet, factory, office			28f. Location (	Street and	Number or	Rural R	oute Number.	
5.	d in I	ert	4 ☐ Homicide determined	building, et	c. (Specify)					City or To	wn, State)				Ŋ,
	nera nera y fille		29a. Certifier 1X Certifying P	hysician: To the best	of my know	ledge, death	occurred at the tim	ne, date ar	nd place, a	and due to the	cause(s)	and manner	as state	ed.	
÷	n 24 n 24 ne Fu	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	of examination	on and/or inv	vestigation, in my or	pinion, dea	th occurre	ed at the time,	date and	place, and d	ue to th	e cause(s)	
:	In the Aboylial of Attending Physician: The law requires that the death certificate be executed within 24 hospital and eath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ž	29b. Signature and title of certifier		ı		29c. License	number			29d. Date	signed (Mo	nth, Da	y, Year)	
			/ ()		MD		D0064	1986			larch	14, 2	008		
7	1/2	ŀ	30. Name and address of person who	completed cause of c	death (Item 2	23a) (Type, F									_
	2		Chike Onwuka, MD				ent Parkwa	ay Su	ite	200 Co	Lumbi	a, Md.	21	044	
	Stat														
	Registra	ır	MAR 1 9 200	8	A. A.	See Francis									

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Henry Karngar 12, 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Layhill Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06-05-24 242 5. Social Security Number 214-59-8303 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F Liberia Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits DC Washington 1 ☐ Yes 2 No Director Oe. Street and Number 321 Sheperd St. NW 10f. Zip Code 20011 10g. Citizen of What Country? Liberia Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: Black 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Neppay Garway Karngar Member 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Shepherd St. NW Wash. DC 20011 19a. Informant's Name/Relationship (Type, Print) Joanna Karngar/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem 4-5-2008 Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Ronald Taylor II FH 21. Situature of Funeral Service Licenses 108 W. North Ave. Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) aMetastatic Prostate Cancer /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Wursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending Injury

Examiner physician and the burial-trans P.O. Box 68760. physician as use for as been signed by the a 2 should be detached it Division or Vital Records, page Hospital or Attending Physician: funeral director, After this i after death. the filled in by 24 hours a E Funerail within 24 hou

To the Fune

completely fi

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Ly or other traumatic event, the Medical Examiner must be notified at Juy or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1
Department of H
important: If ite
any injury or ot

Baltimore, Maryland 21215-0036

ms 23a or 28a-f show must be notified at

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To the I

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058965 March 18, 2008

M

1 ∏Yes 2 ∏No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 9 2008

investigation

6 Could not be determined

Saima U. Khawaja

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

11119 Rockville Pk #100 Rockville, MD 20852

State Registrar

Medical

31. Date filed (Month, Day, Year)

2 Accident

3 ☐ Suicide

4 Homicide

2. Registrar's Signature

		1 _ For State	State of Maryla		artment of F ertificate of		-		n, yang yan, yan,	and the time print 1
		Registrar  1. Decedent's Name (First, Middle, La	st)	<i>UE</i>	runcate or	Dealli	2. Date of De	Reg. No.	008	3. Time of Death
Physic /Medi		Ida Kat	· <del>2</del>				Month MARCH	16	2008	2:05A M
Exami Funeral Director	₹¢	4a. Facility Name (If not institution, given SEASONS HOSPICE (  5. Social Security Number 6. S  216-01-8736	NORTHWEST H	OSPITAL rs. last birthday 9 Yrs.	RANDAL	LSTOWN If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 03/27)	th	BALTIM 9. Birth	place (State or Foreign
<u> </u>		Usual Residence of Decedent		City, Town or L	ocation		00/ = . /			10d. Inside City Limits
faryla show	ō									1 □Yes 💥 No
the M 28a-f notifii	Director	MD BALTIN  10e. Street and Number	IURE	OWINGS	10f. Zip Code			10q. Citize	n of What Cou	ntry?
h with 23a or st be		4730 ATRIUM COL	JRT, APT. 168		2	1117			USA	
be filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💢 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		. Race - Ameri Black, White, pecify: WH	
"natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of worl	king	16b. Kind	of Business/Ir	ndustry
filed within Hygiene. other than "	mo duo	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	HOMEMAK			:	OWN	HOME
al Hyg other	Be C	17. Father's Name (First, Middle, Last	)		.,	18. Mother's Nam	e (First, Middle	, Maiden St		
Menta Menta arked atlc e	10 2	ARTHUR		RU	D0	SARA	H			COHEN
and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationship ( MORTON KATZ /	SON	3435	ling Address (Street PHILIPS	DRIVE, P	KESVILL	E, ME	2120	8
permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "f any injury or other traumatic event, the Med once.		20a. Method of Disposition 1∭ Burial 2  □Cremation 3  □ 4  □Donation 5  □Other ( <i>Specil</i>	Hemoval from State		position (Name of ematory or other pla TLOH CONG		Date 3/2008		Ition - City or T	,
permit. Depart Import any Inj		21. Signature of Funeral Service Licer	7		22. Name and Addre	SC TERSTOWN	DL LEVII RCAD -	PIKES		
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the done cause on each line.	1	nter the mode of dyi		or respiratory a	arrest,		Approximate interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	)					
/ P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons		5/ -					
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ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		23	d. Date of deliv	very Day Year				
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w require been sig should b		preumorya					1 🗆	Yes 2	No 3□ Pro	obably 4 □Unknown
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Iclan; sertific ector,	Be (	25. Was case referred to medical examiner?	Hospital:		l Ott	26. Place of Dea	th (Check only	one)		
Physician: r this certifica	۲: ا	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of injury	2 ER/Outpati	ent 3 DOA	4 ☐ Nursing H	ome 5 ☐ Res 28d. Describe		-	in) Hospice inputs
nding th.	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year		Wo	rk? ]Yes 2∐No				
after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp.	t home, farm, s ecify)	street, factory, office		28f. Location ( City or To	(Street and wn, State)	Number or Ru	ral Route Number,
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medical C		nysician: To the best of my miner: On the basis of exam and manner stated.							
To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month	, Day, Year)
		Carl D. 5	Hoger ms	<b>)</b> .	De	8628		3	116/	08
()		30. Name and address of person who	completed cause of death (	tem 23a) (Type	e, Print) Bodce	S, Elk	ton M	D. c	192	
St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 9 2	32 degistrar's Si	gnature	Brage S	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08852

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Funeral Director

Phys /Me Examin

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

sicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year											Year	3. Time of	
edic	Louise S. Logsdon March 9, 20													9:52	PM M
min											of Death				
		Springvale Assi	sted Livi	ng						Spring		ont	gomer	<b>·Y</b>	
ral		5. Social Security Number 6.	Sex 7. 1 □ M 2 1 F		last birthday,	If Under Months		If Under Hours	24 Hrs. Min.	(Month, Day	, Year)		9. Birthpl Coun	lace (State o	r Foreign
or		509-12-5902	TLIVI ZEST	88	Yrs.					09/04	/191	9	МО	**	
	-	Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Le	ocation							11	0d. Inside Ci	ty Limita
	_	Toa. State Tob. County		100. 010	y, rown or E	ocation							"	1 ZYes	
	50			Wa	ashing										
	Director	10e. Street and Number				10f. Zip	Code						Vhat Coun		
	<u>a</u>	2014 Pierce Mil:	_				0010-						Sta		
	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori an, Mexica	rigin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	.   1		e - America k, White, e		
	by F	1 □ Never Married 2 □ Married	1 ☐ Yes 2 If Yes, Give	7/4		1 🗆 Yes	2 <b>⊠</b> No	Specify:	:		1	Specify:	v.rl. d	4-	
	g D	3 ☑ Widowed 4 ☐ Divorced	Year or Date	s: 	10- B	4. 4. 11.	.1.0	. 4*					MIII		
	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)		Give	edent's Usu e kind of wo DO NOT u	at Occup	ation during mos	st of work	king			siness/Ind	ffice	
	립	Elementary/Secondary (0-12)	College (1-4	or 5+)		ice M					200			21100	
		17. Father's Name (First, Middle, Las	(f)		011.	ice M	anay		er's Nam	e (First, Middle,	Maiden !	Surnam	(a)		
	Be	George Peter Swe	_					Luc		Chavanne	maraon (	Jaman			
	ဥ				10b Maili	ing Addross	Ctroat		-	ral Route Numbe	r City or	Tourn	State Zin	Code	
		19a. Informant's Name/Relationship Patrick J. Logsd					,			sda, MD		,	State, Zip	Code)	
	-	20a. Method of Disposition	On/ 50n	20h F						Date			City or To	www. State	
		1 ☐ Burial 2 【A Cremation 3		ile	Place of Disponentery, cre			1		Mar 12				Maryla	and .
	-	4 □ Donation 5 □ Other (Spec	**		hesape					2008	ьел	LESV.	iiie,	Maryro	and
ouce,		21. Signature of Funeral Service Lie	ensee	MOO.	382 2	2. Name ar Rapp	Fune	ral &	Cren	nation Se	rvic	es			
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		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cau y one cause on eac	sed the deat h line.						or respiratory ar	rest,			Approximat Interval Bet Onset and I	ween
an		Immediate Cause (Final disease or conditiona. Covarant atherosalerosis											orroot arra		
al er		Immediate Cause (Final disease or condition resulting in death)  a. Course a consequent of):  Due to (or as a consequent of):  Course two heart / sulture													
- 3		Sequentially list conditions, b. Congestive heart / sulwe													
	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying													
	саш	Cause (Disease or injury that initiated events resulting in death) Last	C		wanta of):									<del></del>	
1			Due to (or	as a conseq	juerice or).										
	cian/Medical Examiner	d													
	Me	IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of de-											1		
	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	n 2 ☐ Feta	aldeath 3			,			2	3d. Dat Mo	te of delive	,	Year
		1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4☐Pregnan 9☐Unknow	t at time of d n	death 5	Other (s	pecify)							,	
	Completed by Physi	Part II. Other significant conditions	contributing to dopt	h hut not ron	ulting in the I	undorlying o	anico aive	on in Port I	1	220 Did to	phacco u	ee conti	ribute to th	ne cause of o	leath?
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	e l									24a. Was	SV	2	prior to cor	psy findings mpletion of c	available ause of
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	Be (	25. Was case referred to medical examiner?							e of Deat	th (Check only o	ne)				
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	Ë	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	njury Day Year)	28b. Time of Injury	of 2	28c. injur Worl	y at k?		28d. Describe h	now injury	occurr	red		
	atic	2 ☐ Accident investigation				М	1 🔲	Yes 2□	] No						
	titio	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of	injury - At he, etc. (Specif	ome, farm, st fy)	treet, factor	y, office			28f. Location (S City or Tox	Street and vn, State)	Numb	er or Rura	al Route Nun	nber,
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	Medical Certification:	(Check only 2 Medical Exa	Physician: To the beaminer: On the basi												s)
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	2	29b. Signature and title of certifier				29		e number				_		Day, Year)	0
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Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** March arson 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Medical Center Bayview Johns Hopkins Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 84 1X M 2□F Towa 480-16-4178 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Baltimore Nottingham Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or r must be r USA 21236 6 Lark Meadow Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1X∑/Yes 2 ☐ No If Yes, Give Year or Dates: "natural", or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ST and A stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom of the stroom 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Acccountant Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Baker Marjorie Louis Julius Larson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 204 Dorsey Lane Milton, De. 19968 Son Steven D. Larson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. N Burial 2 ☐ Cremation 3 ☐ Removal from State 3-19-2008 BelAir Md. BelAir Memorial 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burin a. Weller Schimunek Funeral Home 9705 Belair Rd. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hupoxemia **Physician** /Medical Du (or as a consequence of): Examiner espirotory Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due o (or as a con equence of) Examiner Due to (or as a consequence of aspirotio igned by the attending physician and be detached for use as the bunal-tra by Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient Certification: To this 28b. Time of filled in by the funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral C 29a. Certifier Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Follmar, MD Wolfe

Street, Baltimore, MD

29d. Date signed (Month, Day, Year)

March 16,2008

State Registrar

North 600 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 9877 3-20-08 vt.

State of Maryland Department of Health and Mental Hygiene amend item 1 per md 9877 3-19-08 avt.

Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maple Jane Leonard Day 2008 <del>Jane</del> March 13, **Physician** 6:34 ам Mapel Jane Leonard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 423 North Church Street Frederick Thurmont If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 01/07/1954 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Min. 567-04-1365 1 □ M 2 ₩ F 54 Hours Yrs Director OH Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Frederick Thurmont 1XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 423 North Church Street 21788 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dennis Lee Crank Myrtle Jenny Eblin Eblin ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jody Crank / Daughter 423 North Church Street, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenfield Cemetery March 18,2008 Greenfield, OH 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Chrmi /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) det ched f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1**X** Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1∐ Yes 2 No To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 \( \sum \) Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) မှ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar KERTI

31. Date filed (M

Year)

Mis.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 733 p 03-16-2008 Sharon Mangione /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 🗓 F 213-60-7237 55 05-28-1952 Maryland Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Maryland Fork 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6509 Upland Dr. 21051 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify Specify: White Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Ed Teacher Balt. Co. Schools permit. Pages 1 and 2 should be filed. Department of Health and Mental Hydle important: If them 27 is marked any injury or other to once. is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Haas Gloria Norris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis J. Manigone (Husband) 6509 Upland Drive Fork, MD 21051 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 03-21-2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** any /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed' certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 25205 , un 30. Name and address of person who completed cause of grath (Item 23a) (Type, Print) Churces & Galto and 2120% 10 6701

State Registrar 31. Date filed (Month, Day, Year)

MAR 19

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Month **Physician** 125 Marin 100C /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memoria 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2√F Hours **Director** Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "neturel", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b, County 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) rovernm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/3/9 19a. Informant's Name/Relationship (Tube. Plin) auch for permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of the such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bacteremia month /Medical Due to (or as a consequence of): Examiner ardiomyopathy year. Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): NIEK attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 Probably 4 Unknown 24a. Was an autopsy performe Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has To the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death. Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatuse and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. March AT 24 38 946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Mumorial Hospital, MD Vova Tain M. D 31. Date filed (Month, Day, Year) 32. Restrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** March Michael Mattz 14. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 108 Mountain Road Linthicum 1 Vear | If Under 24 Hrs. Anne Arundel

9. Birthplace (State or Foreign Country) If Under 1 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Yrs. Director July 26,1956 California 568-23-5653 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 No Director Maryland Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Mountain Road 21090 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ^{Specity:} American Indian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Auto Mechanic 12 permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If item 27 Is marked other I any In]ury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milford Daphna Parsons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 108 Mountain Road Linthicum, Maryland 21090 <u>Bernadine L. Mattz (Wife)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 3/18/08 Brooklyn Park, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee Allins 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to ( as a consequence of): Examiner PATITI Sequentially list conditions, if any, leading to ininhediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★No 24a. Was an autopsy performed? certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Marsidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2008 MAR 19 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No-3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 10:00P 2008 MARCH 11, JANICE MAULDIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY SILVER SPRING HOSPITAL HOLY CROSS Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number Days Months **Funeral** Hours 1 ☐ M 2 🕱 F Washington, D.C 15, 1959 49 Jan. 578-84-3381 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ence. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1★ Yes 2 No Director Prince Georges Bladensburg Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20710 Funeral 4249 58th Ave. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EDucation 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jimmie Mauldin Lucinda Montgomery ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 4249 58th Ave. #10 Bladensburg, Md. Mauldin / Daughter Keyona 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 → Burlal 2 □ Cremation 3 □ Removal from State Clinton, Md. Resurrection 3/18/2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope.
5538 Mariboro Pike/ Forestville, Md. 21. Signature of Funeral Service Lice 20747 23a. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failury. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Carcinoma of Unknown Primary **Physician** /Medical Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Acute Respiratory Failure The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, attending physician Acute Renal Failure Physician/Medical for use as IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ cate has been signing 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 1 1 1 Yes 2 No 2 **X**No certificate Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐No 1 🔀 Inpatient Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 12, 2008 D62520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, Md. Maria D'Arbela, M.D. 32: Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 9 Z003 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	- negistrar	rtificate of Death	Reg	. No. 2008	08859						
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month March	Day Year 16, 2008	3. Time of Death  8:46 A ^M						
	/Medic Examin	_	Joseph Arthur Muldoon, Jr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	inar cii	4c. County of Death							
			18500 Beallsville Road	Poolesville If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgomery	nplace (State or Foreign						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	(Month, Day, Y	(ear) S. Col.	intry)						
	-	ŀ	578-38-9932		August 24	, 1931 mass	10d. Inside City Limits						
	arylan show d at	5	10a. State 10b. County 10c. City, Town or Lo				1 ☐ Yes 2 No						
	the M	Director	Maryland Montgomery Poolesvi	1e 10f. Zip Code	100	g. Citizen of What Cou	untry?						
	h with	io le	18500 Beallsville Road	20837	II	nited Stat	es						
	r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	rican Indian,						
20	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 □ Never Married 2 및 Married 1 □ Yes 2 및 No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi.	te						
0500-CIZ	72 hou natura lical E	ted	15 Decedent's Education 16a Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	6b. Kind of Business/I	ndustry						
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ם ס	filed Hygi other	ပ္ပ	5+ Ow	ner/ Attorney 18. Mother's Nam	ne (First, Middle, Ma								
yland	uld be Mental rked c	To Be	Joseph A. Muldoon, Sr.		eve Shaw								
Mar)	12 should be n and Mental r is marked of raumatic ever		, , , ,	ng Address (Street and Number or Ru									
<u>د</u> ش	and lealth m 27 her t			00 Beallsville Ro	ad, Poole	sville, Man Oc. Location - City or	ryLand 2083/_ Town, State						
Ö E	Pages ient of nt: If ii ry or o		1 ☑ Burial 2 ☑ Cremation 3 ☑ Hemoval from State	ry's Cemetery 200	h 25,	arnesville	.Marvland						
Baitimore,	permit. Pages 1 Department of F Important: If ite any Injury or ot		21. Signature of Funeral Service Icensee	2. Name and Address of Facility obert A. Pumphrey F	uneral Ho	me/Rockvil	le, Inc.						
D	20 E # 9		M00896 3	00 W. Montgomery Av	e., Rockv	ille, Mary	Approximate						
	Dharisian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Fin.										
	Physician /Medical		disease or condition resulting in death)  a. Netastatic Prosta Due to (or as a consequence of):	te Cancer			15 years						
	Examiner		Sequentially list conditions, b.										
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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68760,	tificate be executed g physician and as the burial-transit	edical	d										
			IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of del	liverv						
. Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/N	in the past 12 months?    1	☐Ectopic pregnancy ☐ Other (specify)	_	Month	Day Year						
P.O.	at the de by the a	hys	9 ☐ Unknown	underlying course sires in Part 1	23e Did tob	acco use contribute to	the cause of death?						
	w requires that been signed to should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Fait i.			robably 4 Unknown						
Records,	w requ	Completed			24a. Was ar	24b. Were at	utopsy findings available						
	The lay	omp			autops perform 1 Yes 2		completion of cause of s 2 □ No						
Vital	siclan: The law s certificate has I lirector, page 2 s	Be C	25. Was case referred to medical examiner?		ath (Check only one	**							
or <	Physic rthis or ral dire	은	1   Yes 2   No			nce 6 Other (Spe	ecify)						
on	nding P th. :: After e funera	tion	1 l∰Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No									
Division or	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)	treet, factory, office	28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,						
ā	oltal o urs aft eral Di illed in		29a. Certifier 1 ₩ Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	e, and due to the ca	ause(s) and manner a	s stated.						
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical	29a. Certifier  (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, de (2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	urred at the time, d	ate and place, and du	e to the cause(s)						
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon							
	1		Main My His	D28768	1	March 17,	2008						
	18		30. Name and address of person who completed cause of death (Item 23a) (Type Mario, Ficenberger, M.D., 1650, Orleans		Marvland	21231							
		ate	Mario Eisenberger, M.D. 1650 Orleans 31. Date filed (Month, Day, Year)  MAR 1 9 2008	carle									
	Regist	rar	MAR 9 ZUUO JAMESAN NO JAY										

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla	•	artment of H		Mental Hy	giene	
			Decedent's Name (First, Middle, Las	t)				2. Date of De	eath Z	3. Time of Death
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100	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat		4c. County of	
	LAGIIII		7753 Outing	3 Avenue		Pasade	ena		Anne	Arundel
	Funeral Director		5. Social Security Number 6. Se		s. <i>last birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	rth 9	Birthplace (State or Foreign Country)  Maryland
	pui »		Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or Lo	ocation				10d. Inside City Limits
	e Maryla Ba-f shor	ctor	Maryland Anne A			sadena				1 □ Yes 2 No
	23a or 2 ust be no	Funeral Director	10e. Street and Number 7753 Outing Aven	ue		10f. Zip Code	1122		10g. Citizen of Wh	*
920	be filed within 72 hours after death with the Maryland tital Hyglene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 MiDivorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No to Rican, etc.)	Black,	American Indian, White, etc. White
5-0	72 ho natur lical	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	i (Give	dent's Usual Occup	during most of wa	rkina	16b. Kind of Busi	ness/Industry
2121	d within giene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire Waitress	d)		Restura	int
Baltimore, Maryland 21215-0036	2 should be filed and Mental Hygin is marked other raumatic event, the	To Be (	17. Father's Name ( <i>First, Middle, Last</i> )  James	Heller			18. Mother's Na Mar		a, Maiden Surname) atthews	
, Mar			19a. Informant's Name/Relationship (7 Deborah J. Grana)			-			ber, City or Town, Si e, Marylar	
more	Pages 1 and ment of Health ant: If item 27 lury or other t		20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	osition (Name of matory or other pla Cremator		Date 19-08	20c. Location - C Baltimor	ity or Town, State
Balti	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service Licen	Druck	Mg	2. Name and Addre Cully-Po 3204 Moun	ess of Facility 1yniak Fr tain Road	uneral H	lome P.A. Lena. Mary	land 21122
	Physician /Medical Examiner		23a. bert1. Enter the disease, or companock, or heart failure. List only mediate Cause (Final disease or condition resulting in death)	of tions that caused the decline cause on each line.  a	ath. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory		Approximate Interval Between
J.	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any leading to innecessate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse						
8760,	the burial	dical E		.d						
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date Mont	•
Δ.	signed by		Part II. Other significant conditions of	ontributing to death but not re	esulting in the c	underlying cause giv	ven in Part I.			oute to the cause of death?
or Vital Records,	e law requir has been si je 2 should b	Completed by	DIABER	Melli	evit.				opsy pr	ere autopsy findings available for to completion of cause of eath?
a								1□ Yes		Yes 2X No
ξ	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oti	nor:	ath (Check only	orle)	
n or	Ing Phys After this uneral dir	on: To	1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c. Inju	ry at rk?		sidence 6 Other how injury occurre	
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				]Yes 2∏No —	28f. Location City or To	(Street and Number own, State)	r or Rural Route Number,
_	Hospita 24 hours Funeral stely filled	edical Co	29a. Certifier (Check only one)  Certifying Ph. 2 Medical Examone)	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) and man e, date and place, a	ner as stated. nd due to the cause(s)
	To the within 2	Mec	29b. Signature and title of certifier	mp		29c. Licens	se number		29d. Date signed 3 , 18 , 2	(Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAR 1 9 2008

MAJEKODUNMI KUNNI 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7206

HANOVER

TORBOINT

MD.

21076

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 March 7:45 A M Oliver Jr. Jesse 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Aberdeen 399 Stratford Ave. 8. Date of Birth (Month, Day, Jan. 6 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1**√** M 2 □ F North Carolina Jan. 1948 60 216-54-0148 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Aberdeen 1 ☐ Yes 2 No Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21001 399 Stratford Ave. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CS and D Inner Harbor Architect 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Setzer Oliver Sr. Vivan Α. jesse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 399 Stratford Ave. Aberdeen, Maryland 21001 Mary E. Oliver (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Marchate17, H Burial 2 ☐ Cremation 3 ☐Removal from State Lake View Memorial Pk. 2008 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. a 1005 Dundalk Ave. Baltimore, Maryland 21224 23a Part1 Enter the disease, or complications shock, or heart failure. List only one part of hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LYOCARDIAL CUTE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

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**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Mental H

Pages 1

permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If Item 27 is marked ot any Injury or other traumatic ever

attending physician for use as the buria page 2 s

Examiner Physician/Medical þ Completed Be Medical Certification: To

funeral

hours after death uneral Director; filled in by the

24 hours a

the within To the

Hospital or Attending Physician: The law requires that the deeth certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

autopsy performe 1∏ Yes 2 🗹 No

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case refe examiner?	erred to medical		26. Place of Death (Check only one)							
	] No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ □	OOA Other: 4 Nursing H	ome 5 Residence 6	□Other (Specify)				
27. Manner of Dea 1 X Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State,	d Number or Rural Route Number, )				
29a. Certifier (Check only	1 Certifying Pt 2 Medical Exa	nysician: To the best of my knominer: On the basis of examina	owledge, death occurre	ed at the time, date and place on, in my opinion, death occu	, and due to the cause(s)	and manner as stated. place, and due to the cause(s)				

and manner stated 29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 North Charles Street Baltimore, Maryland 21204 Paul Valle M.D.

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** 15, 2008 6:10 P. March O'CONNOR HEINTZ TRMA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Cockeysville Broadmead Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F Yrs 1914 Maryland 215-10-1372 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location the Maryland 10b. Count Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23e or 28a-1 show ury or other traumatic event, the Medical Examinant manake nothing an 1 ☐ Yes 2√2 No Directo Baltimore Towson Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 U.S.A. 629 Coventry Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Baltimore, Maryland 21215-0036 White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lang Anna 2 Louis Heintz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (son) 1703 Campbell Road Forest Hill, Maryland 21050 William H. O'Connor, III 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3-19-08 Pikesville, Maryland Druid Ridge Cemetery 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee renais 6500 York Road Baltimore, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final disease or condition resulting in death) Wreek **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 12 No 3 Probably 4 Unknown Be Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 2 No 1 TYAS 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital: 4 ursing Home 5 Residence 6 Other (Specify) 20 No 2 ER/Outpatient 3 DOA 1 Yes 1 Inpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Diatural 1 🗌 Yes death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after deat To the Funerel Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 - Homicide To the Hospital 1 D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 25 (Type, Print) 31. Date filed (Month, Day, Year) MAR 19 32. Registrar's Signature State Registrar

3/15/08

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12, 2008 Year **Physician** 12:20PM Frances H. Powell March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Cherry Hill Nursing Home Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 X F 88 1919 216-12-0289 15, Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner misser. 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland | Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 13401 Old Chapel Road 20720 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver H. Bayne Ida Baublitz ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Powell/ Son 13401 Old Chapel Road Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans Cemetery 3/18/2008 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebro Vascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to (or as a consequence of): Examine The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760€ Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 5 ☐ Other (specify) 4⊡Pregnant at time of death been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate I 2 No 1 ∐Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. May er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier D51051 30. Nam And address of person who completed cause of death (Item 23a) (Type, Print) Ligon Rd, Ellicott City, MD 21042 3621 ŕ Sala 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Рм Dorothy L. Pearson March 12, 2008 3:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent Center Crofton Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🗓 F 308-36-1847 94 30, 1913 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland | Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1584 Bandury Court 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 20XNo Specify: Specify: 3XXWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Smith Anna Marie Mathias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Clapp/ Daughter 1584 Bandury Court Crofton, MD 21114 20b. Place of Disposition (Name of cametery, crematory or other place)

Lakemont
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 3/18/2008 Davidsonville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Li 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2041 Certify huser Due to (or as a consequence of): dioneyon othy with Congesture Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) O Cestre Due to (or as a consequence of) IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 1∐ Yes 2 1 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

**Examiner** The law requires that the death certificate be executed Exami ician and burial-trans Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical signed by Completed by icate has been sig r, page 2 should b Physician: director Be ၉ this After thi funeral of Certification:

Physician

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Medicai

s 1 and 2 should be filed within 12 of Health and Mental Hygiene.
If Item 27 is marked other than "r

permit. Pages
Department of H
Important: If ite
any injury or of

**Physician** 

/Medical

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: Completely filled in by the f P Fo the Hospital

State

Medical

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SROKA, MB, 1684 VILLAGE GREEN, CROFTON MD 21114

Registrar

29a. Certifier

(Check only one)

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 larch Patel Shantaben J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie 8. Date of Birth (Month, Day, Year) August 25,1917 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X Director 218-08-7124 91 India Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10d. Inside City Limits 10b. County a or 28a-f sho t be notified a 1 ☐ Yes 2 XNo Director Anne Arundel Crofton Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ", or items 23a c aminer must be 1750 Wickham Way 21114 India by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Iten may injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify. 3 Widowed 4 Divorced Year or Dates: Asian-Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pate1 2 Bhikhabha Patel Diwaliben 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, Maryland 21114 Amrut J. Patel/son 1750 Wickham Way 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 3/17/2008 Odenton, Maryland 21. Signare of Funeral Service License 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 12 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an has autopsy perform certificate has irector, page 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3 DOA 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physiclan; s after death.

I Director: A

of in by the fu the Hospitai within 24 hours a completely

> State Registrar

Medical

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Ho square in ive source 202

GURMEET S. SAW HWEY MD GenBurnie MD 21061 31. Date filed (Month, Day, Year) 32 egistrer's Signature MAR 1 9 2008

29b. Signature and title of contifler Aftending

DHMH 17 Rev 1/2001

Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 930 Day 03 08 Perez-SANCHEZ PM. rctor 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Seasons Randallstown Inpatrent Unit If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday 5. Social Security Number Days Hours 1 X M 2 ☐ F 1955 Puerto Rico March 22, 215-70-3098 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 XNo Anne Arundel Severn Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21144 7713 Pecan Leaf Road 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: 1976-97 1 ☐ Never Married 2 ☑ Married 1X Yes 2□ No Specify: White Puerto Rican 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) United States Army Master Sergeant 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sanchez Francisca Abraham Perez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severn, Maryland 21144 7713 Pecan Leaf Road Maritza Perez/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville, Maryland Maryland Veterans Ceme 3/19/2008 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Donaldson Funeral Home & Crematory, Odenton, Maryland 21113 1411 Annapolis Road Homas ations Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition saraure resulting in death) Due to (or but consequence of): Brain Ca Due to for as a consequence of Due to (or as a consequence of) If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical Examiner

The law requires that the death certificate be executed

Records, P.O. Box 68760.

Division or Vital

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 minjury or other traumatic event, the Medical Examiner must be n once.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

Completed by

Be

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Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last burial-tran Physician/Medical use as the IF FEMALE: 23h Was decedent pregnant for in the past 12 months? 1 ☐ Yes 2 ☐ No detached the 9 Unknown à þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical director, 25. Was case referred to medical Be 1 Yes 2 No 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 | Pending investigation 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

24a. Was an autopsy perform 2 **X** No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Pospre Line 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

mo nea 30. Name and address of erson who completed carse of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

State Registrar N.B

2 ER/Outpatient

28b. Time of

Injury

3□ DOA

28c. Injury at Work?

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Esther Hester Moss 11:28 A 2008 March 15 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson If Under 1 Year | If Under 24 Hrs. Tanha | Days | Hours | Min. Baltimore Greater Baltimore Medical Center Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 247-90-3379 1 ■ M 2 ■ F 336.1950 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD 1 ☐ Yes 2 ☑ No **Funeral Director** Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20 Chriswell Court 21237 U.S.A 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ Ne If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) larget 12th Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Shaultze iessie Watkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Harris 20 Chriswell Court Baltimore MD 21237 ce of Disposition (Name of Date 20c. Location - City or Town, S 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Garden of Faith Baltimore MI 3/21/2008 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughn C. Green Furera Servis 21. Signature of Funeral Service Licensee /21212 Baltimore, MI) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bacterial **6075** Due to (or as a consequence of): Syndrome of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 □ No 24a. Was an autopsy performed' 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Examiner To the Hospital or Attending Physician: he law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. attending physician certificate this After t within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician/Medical Completed Be မှ Medical Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mergnee."

**Physician** 

/Medical

29a. Certifier

1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

29b. Signature and title of certifier

5 Pending investigation 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

47221

29c. License number

29d. Date signed (Month, Day, Year)

mpleted cause of death (Item 23a) (Type, Print)

Charles St. Baltimore, MD 21204 m. D. 6701 N. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

2008



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & State of Maryland & Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** RILET WILLIAM MMCH 17 JULY /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 212-28-5124 77 Director 02/07/1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental hygiene.
ant: If Item 27 is marked other than "naturat", or Items 23a or 28a-1 shov ury or other traumatic event, the <u>Medical Examiner must be notified at</u> 1 ☐ Yes 2 No MD. Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 Foxford Stream Road 21236 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 □ No If Yes, Give Korean Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Network Elementary/Secondary (0-12) College (1-4or 5+) Publications Accountant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Riley Catherine Neubert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 Foxford Stream Rd. Baltimore, MD. Mrs. Helen B. Riley/ wife 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: if Ite any injury or ot St. Joseph Catholic 03/20/08 1 Burial 2 □ Cremation 3 □ Removal from State Fullerton, MD. 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 a3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diate Cause (Final Physician CUNGUSTIUG HEMMT resulting in death) /Medical Due to (or as a consequence of): Examiner CUNUNMY moreny DISLASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit MITEMIUSCIENUNG CARDIOVASCHUM DISEASÉ Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending p for use as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) has been signed by the a part of a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached in a second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second by the second be detached by the second by the second be detached by the second by the second be detached by the second be detached by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by the second by t Tyes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, CIMUNIC UBSTRUCTUS PALMONTY DISEAGE 2 No 3 Probably 4 Unknown Completed PULMUNMY HYDERTENSIUN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate har funeral director, page 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury To the Hospina. .. within 24 hours after death.
To the Funeral Director: Aftrammetely filled in by the fur 5 ☐ Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MANCH 17, 2004 D15135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOLD ADVER DIVD BALTIMUNE, MD 21239 P. SLOTT MD 5611

Registrar

State

31. Date filed (Month, Day, Year)

MAR 1 9 2008

32. Rigistrar's Signature

Physician /Medical Examiner

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within 24 hours a To the Funeral

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attending physician

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

rthan "natural", or Items 23a or 28a-f shov Its Medical Examinar must be rediffed at

**Funeral Director** 

Completed by

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be filed within Health and Mental Hygiene. am 27 Is marked other than "

permit. Pages 1 and 2 s
Department of Health ar
Important: If itam 27 Is
any injury or other trau

that initiated events resulting in death) Last

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2. No

26. Place of Death Check onl one

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) investigation

28b. Time of

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident

3 🖺 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 20065-918

29d. Date signed (Month, Day, Year) 03/16/2008

28I. Location (Street and Number or Rural Route Number, City or Town, State)

MD Stin

West Belyedore Avenue, Baltimore, MD, 2434 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For amend #26 Per Phy C877 3/19/08	ertificate of i	Death	тепцат пуд в	eg. No.	08870	
ø	Physicia	ın	1. Decedent's Name (First, Middle, Last) ALLEENE B. SHERMAN			2. Date of Dear	Day Year	3. Time of Death	
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	March	16, 2008 4c. County of Death	9:20 a M	
A .53%			7723 Locust Grove Road						
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 12	Year) Cor	pplace (State or Foreign intry) th Carolina	
	/land ow at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits	
	e Many ta-f sh	cto	Maryland Anne Arundel Glo	en Burnie				1 ☐ Yes 2 No	
	be filed within 72 hours after death with the Maryland Hylgiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 112 2nd Avenue North	10f. Zip Code	061	1	0g. Citizen of What Co. U.S.A.	untry?	
	tems ler mu	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White		
U30	within 72 hours after ene. than "natural", or ite he Medical Examine	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	1 ☐ Yes 2 1 No	Specify:		Specify: Wh	ite	
315-0036	72 ho "natur dical i	Completed by	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occup ive kind of work done o. DO NOT use retired	ation during most of work	ring	16b. Kind of Business/I		
7	within jene. r than the Me	ошо	Elementary/Secondary (0-12) College (1-40r 5+)	hool Teac			Anne Arund Schools		
na	be filed vital Hygie d other i event, the	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle,	Maiden Surname)		
yland	2 should be and Mental Is marked of raumatic ev	2	John Batchelor	silina Addusas (Cánas	Iv	-	Baker r. City or Town. State. Z	Tin Code)	
	nd 2 sh lith and 27 is n r traun		1 (2)					ryland 21060	
ore,	of Hea		20a. Method of Disposition 2 Demoval from State 20b. Place of Discemetery, of	sposition (Name of rematory or other place		Date	20c. Location - City or		
Baitimor	t. Pag rtment rtant: I		4 Donation 5 Dother (Specify) Glen Ha	yen Mem. P			Glen Burnie	· -	
g C	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.		21. Signature of Funera Servi: e License	McCully-Po	lyniak Fu ain Road.	neral He	om <b>e</b> P.A. na, Marylan	d 21122	
ľ			23a Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)					Onset and Death	
	Examiner		Due to (or as a consequence of):						
Λ	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
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<b>68/6</b> 0,	tificate be executed g physician and as the burial-transit	edical E	d						
	ertifica ding ph	Med	IF FEMALE: 23c. If yes, outcome pf pregnancy						
X P P	death o	Physician/M	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death  1 ☐ Vac 2 ☐ No.  4 ☐ Pregnant at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of del Month	lvery Day Year	
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	w requires that the death certific been signed by the attending p should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause giv	en in Part I.	23e. Did to	obacco use contribute to ′es 2 ☑ No 3 ☐ Pr	o the cause of death? obably 4  Unknown	
Hecords,	s been	Completed				24a. Was	an 24b. Were au	utopsy findings available	
_	sician: The law certificate has b irector, page 2 sl	Som					rmed? prior to death? 2☑No 1☐Yes	completion of cause of 2. No	
VIta	Physician: this certificatal director,	Be	25. Was case referred to medical examiner?	tions all poal Oth	26. Place of Dea	,		Daughter's	
ō	g Physer this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Inju	4 LI Nursing H	ome '5 Aesid 28d. Describe h	lence <b>61</b> Other (Spe	cify) Residence	
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ľ	la		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)			- 11.11	<u>*</u>	
	6		Michael Downing 7845 Okhwy: A Log 31. Date filed (Month, Day, Year) 22. Registrar's Signature	d Suite 200	blen Bu	urnie M	0 21061		
	Sta Registr		MAD 1 9 2008	we					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2cc2 Month 12 Lillian Carol Schaa1 12.10 AM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) SALTIMORE WARHINGTON MEDICAL TENTER CLEN BURNIE AHUNE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | June 25, 1950 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 2X F 215-58-2601 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21061 190 Virginia Lane Apt. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ▼ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Housewife & Mother College (1-4or 5+) Elementary/Secondary (0-12) 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bearden Decker Betty Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106119a, Informant's Name/Relationship (Type, Print) James R. Schaal (Husband) 190 Virginia Ln., Apt. G, Glen Burnie, Md, 20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Veteran's Cem. 3/14/08 Crownsville, Md. 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Fundal Service Licensee Kevin E Ecker 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ERRHOSIS UNES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner death certificate be executed

Department of Important: If any Injury or

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/Medical

**Examiner** 

**Funeral** 

Director

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Registrar

ae and address of person who completed cause of death (Item 23a) (Type, Print)

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 45149

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29d. Date signed (Month, Day, Year) March 12 2008

31. Date filed (Month, Day, Year) MAR 19 2008

6 ☐ Could not be

32/Registrar's Signature

and manner stated.

Glen Burne ms 20161

28f. Location (Street and Number or Rural Route Number, City or Town, State)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 3. Time of Death Month March 14, 2008 **Physician** 12:45 PM Elizabeth A. Stone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours Min 1 □ M 2 😾 F China 82 Jan. 6, 033-14-2373 Director Usual Residence of Decedent death with the Maryland 10c City Town or Location 10d Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21X No Directo North Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878-3921 United States 13601 Glenhurst Road Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H r is marked oth Be Edna Marie Soder Earl Draper Alexander, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau 13601 Glenhurst Rd., N. Potomac, MD 20878-3921 Robert H. Stone / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 19. Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2008 Bethesda, Maryland Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Robert A. Pumphrey Funeral Home/Rockville, M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. adays Immediate Cause (Final Cuspiration preumonia

Due to ras a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** cardrac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit electroly te disorder and that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, lymphedemo Physician/Medical ս<del>ւ</del>թու the as 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Pulmonary Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown eizonogastza 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an has autopsy page certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 1 Natural 5 Pending investigation Injury within 24 hours enter occ.

To the Funeral Director Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 14, 2008 Puscella Collabor dels 10 41794 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

175011a Cailakan tyon MD 911 Russell Avenue Galthorsburg, MD 20879 Inscilla Callahan tyon mo 32 Henry ges Signal A

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 14 per fh 9877 3-19-08 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lian Silberman 7:20 AM 2008 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Levindale Baltimore HOSPITOL Baltimore MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country)
POLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Months Days Hours Min. (Month, Day, Year) 10/23/1910 212-38-2533 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notified at 1X Yes 2 No Director MD N/A BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2434 W. BELVEDERE AVENUE 21215 USA items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify. WHITE Specify: 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M SALES CLERK RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SILVERMAN FANNIE UNOBTAINABLE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4104 LOCH CARROW ROAD, PERRY HALL, PAUL SILBERMAN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h important: if ite any injury or of once, 1 Burial 2 □ Cremation 3 □ Removal from State BNAI ISRAEL CONG. 03/18/2008 BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 69 Embral /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) by the a 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 autopsy performed? Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Il Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEIN MP 31. Date filed (Month, Day, Year) Registrar's Signature _o State Registrar

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**Physician** Examiner Box 68760. P.O. I Division or Vital Records,

Baltimore, Maryland 21215-0036

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29b. Signature and title of certifier

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**Funeral** 

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> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOGHBELI, MO JANET 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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WE 55 BALTIMORE, MD 21223

29d. Date signed (Month, Day, Year)

Registrar

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Year 3 38A M lvia Savon acop /Medical 4c. County of Death Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Gilchrist Itospice 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ 5 Yrs. Director 1.a.194a Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Examiner must be notified at M Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21236 U.S. A 12 Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ Ne If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usuai Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security ontract Administrator 2715 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be larence. Margaret ဥ Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adolthus Taylor 3711 Pred Berry Way Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dukney Valley 3/19/2008 Baltimore MD

22. Name and Address of Facility Vausan C. Greene Funeral Services 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 4905 York And Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Physician Cancer disease or condition resulting in death) montres /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the bunal-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 I Inknowh 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2**X**0No Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSQIW 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this s after death.

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of in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours aft

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completely filled ir SEP Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

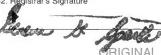
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31. Date filed (Month, Day, Year)

MO 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Moses Thompson 4:57 AM MOURCH 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE 5. Social Security Number Jast birthday) 8. Date of Birth
(Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F -14-898 ઇ Director Peb.20 rainia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director Ma more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ★ Divorced Completed Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OOD Worker 12th house 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ ne 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 fair Kel. mari 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 13 -21-0 Jarrison forest Owings MILLS 21. Signature Funeral Service Licer 22. Name and Address of Facility Fred HILTON march fit. 23a. Part. Er er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse (Final disease or Andition **Physician** cardiac arrest 2 days /Medical resulting in death) Due to (or as a consequence of) Examiner cardiomyopathy 5 YRS ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical as the 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown Completed Were autopsy findings available prior to completion of cause of autopsy death? perform of or Attending Physician: after death. Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Yo Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m alonso KES-000 March, 16,2008 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) MAR 1 9

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:00 KM 2008 Fred Thomas MARC /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F Yrs. Director 9-09-1923 577-22-6331 84 S.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 E.25th St USA Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Specify: Black 1 ☐ Yes 2 K No Baltimore, Maryland 21215-0036 Specify: <u></u> 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Truck Driver 8_{th} 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jordan Thomas ပ Rachel Brevard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health Delores Thomas/Daughter 7702 Hill way Ave Parkville MD 21234

e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pages Department of Important: If It any Injury or o 4 □ Donation 5 □ Other (Specify) 3-14-2008 Baltimore, MD Cemetery Westernof Funeral Serv e Licen Ronald Taylor II Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximated Contract (Figure 2). HM. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY Physician HRONIC OBSTRUCTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1005 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijery that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 1 hpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide ō within 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely

Division or Vital Records, P.O. Box 68760,

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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MAR 1 9 2008

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Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

29c. License number

UNION MEMORIAL HOSPITAL, BALTIMORE, MD

29d. Date signed (Month, Day, Year)

MARCH 10, 2008

and manner stated.

MAY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician 7:35A 16, 2008 Bernard George Wagener, Jr. March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 837 Seneca Park Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. 215.34.8188 Usual Residence of Decedent 70 MD 08.16.1937 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant; If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 ☐ No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 837 Seneca Park Road 21220 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give \( ) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Korea Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beth. Steel Machinist 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Elizabeth Doering Bernard George Wagener, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Wagener/Wife 837 Seneca Park Rd., Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 03.18.08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee P,A. 8717 Green Pastures Dr. Balto., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC 12ARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEART FAILURE ONGESTIVE MORTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of): Examiner attending physician and for use as the burial-transh that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page performed 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funeral dir Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death. neral Director: / 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 03355 #314, BAltIMULE, MB 21237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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Registrar's Signature

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MICHAEL AUERBALH, 31. Date filed (Month, Day, Year)

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DHMH 17 Bev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer 10:00 AM 2008 Lane 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sciothers bu Center Wilson Healthcan 8. Date of Birth (Month, Day, Year) May 1, 1923 9 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🛱 F 84 579-20-5231 Towa Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 19157 St. Johnsbury Lane 20876 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Office Manager Accounting 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy M. Addis Harvey C. Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19157 St. Johnsbury Ln., Germantown, MD 20876 James H. Walker / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Montgomery Crematorium, Inc. March 16, 2008 Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sovice Lice 100 Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage RR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thinknown

Physician /Medical Examiner

Physician

/Medical

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Examiner

**Funeral** 

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72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records.

Examiner burial-transit Physician/Medical use as the be detached þ Completed Be funeral Certification:

attending physician 9 the signed by Physician: his ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th

To the Vithin 2

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 110 24a Wasan 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Augusting Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

March 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ndiel Ferrous

2008

201 Kussell Ave a2. Registrar's Signature 1500

Gatherhung

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY2CH Day **Physician** Irene Elizabeth Walker 1705 200 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Cop Bulh mol Bultimore 121/4/ If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months Days Hours 214-44-3730 Director 9-14-1945 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Baltimore Reisterstan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 Franklin Valley Circle 21136 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 TYes 2 ☐
If Yes, Give
Year or Dates: 2□No African-American 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Account Manager GlobalPayments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McCleaven Bryant Sarah Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 tment of Health 8 40 Franklin Valley Circle, Reisterstown, MD 21136 William H. Walker/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-20-08 Garrison Forest Veterans Owings Mills, MD 4 Donation 5 Other (Specify) 21. Sign re of Funeral Service Licensee 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, ND 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to ( as a consequence of): Examiner denocus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 bortriction 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manpet of Death 28a. Date of Injury 28b Time of 28d. Describe how injury occurred Certification: Year) al or At.
ours after deat.
al Director: At.
in by the fur-(Month, Day Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 □ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMN TIM/IOa.b.C.e.f.19b.berFH.33/7.3/24/08 WS/RB
State of Maryland? Department of Pleatin and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2008 12 M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore If Under 1 Year | If Under 24 Hrs. Days | Hours | Min. Universitu 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2X F Yrs 12-1-1943 M) Director 218-44-5826 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Washington  $\mathbf{m}$ Director **Poltimore** wm MD-10g. Citizen of What Country? 10e. Street and Number
4119 Massachusetts Ave., SE
3205 Blue Hill Road 10f. Zip Code USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: African-American Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5± Social Worker Arlington County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Webb Clarence Angelo Gee ၉ 19b Majing Address (Street and Number or Rural Route Number, City or Town, State 7in Code)

3205 Blue Hill Road, Gwyrm Cak, M. 21207 19a. Informant's Name/Relationship (Type. Print) Larry E. Watters/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 To Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-13-08 Baltimore, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 20 realis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last un Due to (or as a sequence of): Examiner certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the l IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d Date of delivery use 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth Year Month Day for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 No 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cate has been si, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes Hospital or Attending Physician: 26. Place of Death (Check only one) after death.

Director: After this certific
J in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient ٩ 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 22 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar 1 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Eloise Rachel Washington 11/200 08 /Medical 4c. County of Death a. Facility Name (If not institution, give street and number) 6707 Calmos St. 4b. City, Town, or Location of Death Examiner Capitol Heights PG | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 1 (Month Day 1911) 5. Social Security Number 73 7. Age (In yrs Jast birthday) 9. Birthplace (State or Foreign Funeral 1□M 2**X**F Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD PG Capitol Heights 1 Yes 2 No Director 10f. Zip Code 20743 10g. Citizen of What Country? 10e. Street and Number 6707 Calmos St. USA Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2X No Specify þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laundry Worker Georgetown Hospital traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Norris Alice Gladden ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau Delores Davis/ Daughter 6707 Calmos St. Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place Harmony Mem. Pk 20c. Location - City or Town, State Date 20a. Method of Disposition 3-22-08 1 Burial 2 □ Cremation 3 □ Removal from State Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Ronald Taylor II FH 21. Signature of Funeral Service License 108 W. North Ave. Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** aw /Medical Due to (or as a consequence of) Examiner 2020 as. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,~

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the tuneral director, p

Registrar

State

Medical

29b. Signature and title of certifier

29c. License number

🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) -2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Amir Alikhani MD 101 Centennial St.LaPlata,MD 20646

29a. Certifier

31. Date filed (Month, Day, Year) MAR 1 9 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year 2005PM tarch 2008 Mary Hodgson Allen /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dord HOSAI-tal General 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb. 13, Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Hours Min. Vear 1 ☐ M 2 🗹 F 032.18.3598 Feb. Director 81 1927 Massachusetts Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f sh notified a 1 ☐ Yes 2 No Directo Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be be items 23a iner must b 2210 Dailsville Rd. 21613 Completed by Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or ite ury or other traumatic event, the Medical Examine. Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Worker Security permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Item 27 is marked other th any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lannigan Sarah Hetherson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Anthony Allen/Son 2210 Dailsville Rd., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MidShoreCremationCenter 3.15.2008 Cambridge. Maryland 21. A ature of Funeral Service Licensee 22. Name and Address of Facility
Mid Shore Cremation Center,
2272 Hudson Rd., Cambridge, 23a. Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ongestive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Oronary and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the esn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for . □ Yes 2/5 No 9 □ Unknown in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed by the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 212kNo 1 🗌 Yes 3 Probably 4 Unknown Completed Was at autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho 24a. Was an certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death Hospital: 2 1 Appatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 28a. 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Hatural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of contifier 29d. Date signed (Mgnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CWMIE 2 31. Date filed (Month, Day, Year, MAR 1 9 Year) Registrar's Signature State Registrar DHMH 17 Rev 1/2001

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		For State	Plea			Оера	rtment of	Health	and N	-		egible.		
		1 - State Registrar				Cer	tificate of	Death			Reg. No.	088	08883	
Physicia /Medic	W	Decedent's Name  Barbar	_		ams					2. Date of De Month March	7, 20	08 Year	3. Time of Death 8:30 A. M	
Examin	ì	4a. Facility Name (I	f not institutio	n, give street and number)			4b. City, Town,	or Location	of Death		4c. C	ounty of Dea	ath	
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uld b Ment Ment rked rtic e	2	Walt	er A.	Ogle					Lucil	le P. I	rest	on		
and I		19a. Informant's N	ame/Relation	ship (Type. Print)	19k	o. Mailin	ig Address (Strei	et and Num	ber or Ru	ral Route Numl	ber, City or	Town, State,	Zip Code)	
and 3		Patricia	K. Bi	erlich (Sist			Orndoff	Dr.			rbrool		22624	
of H		20a. Method of Disp		3 □Removal from State	cemete	of Dispos ery, cren	sition (Name of matory or other p	lace)		Date		-	r Town, State	
Pag ment ant:		4 □Donation			R. A.	. F∈	erris & (	Co.	3/11	/08	West	Chest	er, PA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	uneral Service	Licensee Line (	shee	Ta Ab	Name and Add arring-C perdeen,	ress of Faci argo I Mary	uner Land	al Home 21001-	3399 ²	A.		
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other						Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year	
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To the Hospital or Attending Physician: The law Within 24 hours after death.  To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one)		ing Physician: To the best I Examiner: On the basis and manner s	of examination a									
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State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Division or Vital Records, P.O. Box 68760 the Hospital or Attending I nin 24 hours after death. the Funeral Director: After

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Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

MAR 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert Isaiah Banks februon 310 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Gerera 7. Age (In yrs. last birthday) hester If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 12-05-1930 5. Social Security Number 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Months Days Hours 213-22-9536 77 Director Maryland Usual Residence of Decedent r 28a-f show potified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Md. Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural" or items 23a or event, the Medical Exeminer must be re-731 Rosemont Ave. 21613 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Electrician/Mechanic National Can Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic ever Lillie Ann Jackson ၉ William Banks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guinervere Banks wife 731 Rosemont Ave., Cambridge, Md. 21613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, Md. Bethel 03-08-08 Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 524 Race Street, Cambridge, Md. 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but notiresulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ ₩o 24a. Was an autopsy this certificate has performe or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

FEB 2 9 2008

Division or Vital Records, P.O. Box 68760

			For State Registrar	State of Mary		rtment of F			giene	08 08889
N.	Dhooisi		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	3. Time of Death
Ž.	Physici /Medic			Russell	Bassett			Februa	ry 27, 2	2008 12:05 ™
	Examin	er	4a. Facility Name (If not institution, give s WILSON HEALTH CAR			4b. City, Town, o GAITHE	r Location of Deat RSBURG	h	4c. County	of Death GOMERY
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Birthplace (State or Foreign Country)
Line .	Director		214-03-4587	M 218 98	Yrs.			10/11/		Maryland
	land ow		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary Fied a	to	Maryland Montgome	ery	Gaither	sburg				1 ∐Yes 2 🛣 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 201 Russell Ave.			10f. Zip Code 20877			10g. Citizen of W USA	Vhat Country?
	death	nera	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No	- 14. Race	e - American Indian, k, White, etc.
36	rs after I", or ite xamine	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Tes, specify Cubic	Specify:	to nicali, etc.)	Specify.	
9	2 hou latura ical E	Completed by	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occup	eation	rkina	16b. Kind of Bu	siness/Industry
215	thin 7 e. an "n Medi	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done OO NOT use retired	•			
21	ed wi ygien rer th t, the	ပ္ပ	12	4	gove	<u>enment</u> pr			goveri	
Maryland 21215-0036	12 should be filed within "h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	Be	17. Father's Name (First, Middle, Last) Oscar Russell					me (First, Middle) Bradley	, Maiden Surnam	e)
Ž	should nd Me mark matic	으	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	g Address (Street			er, City or Town,	State, Zip Code)
	1 and 2 s Health ar tem 27 is	М	Hamilton P. Fox/a		6068	Fox Lane	, Salisb	oury, MD	21801	
Jre,	es 1 a of Hei		20a, Method of Disposition	2	20b. Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location -	City or Town, State
Ē	Page ment ant: M		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	Salisbury			8/08	Salisbu	ary, MD
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service License	OTP	22	Holloway 501 Snow	funeral Hill Rd.	Home Pro	ofession oury, MD	al Association 21804
			23a. Part1. Enter the disease, or complished, or heart failure. List on or	ications that caused the	death. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-	mentia					Onset and Death
	/Medical		resulting in death)	Due to (or as a co						7
	Examiner	L	Sequentially list conditions,	).	and a series of the					
	ted	nine	Sequentially list conditions, if any, leading to immediate Enter Industrial Cause (Disease or injury that initiated events	Due to (or as a co	onsequence or):					
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	e be e	dical E		1						
9	tificati ig phy as the	ledi								
Вох	death certific a attending pl d for use as t	an/N	23b. was decedent pregnant	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐		Ectopic pregnanc	v			te of delivery
.O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown		Other (specify)			Mo	nth Day Year
0	that the de led by the a detached		Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco use contr	ribute to the cause of death?
Records,	luires tha signed ifd be det	d by						1 🗆	Yes 2 No	3 ☐ Probably 4 ☑ Unknown
Ö	w requir s been si shoutd	Completed						24a. Was	an 24b. \	Were autopsy findings available orior to completion of cause of
Re	The lav te has age 2 t	ошь						auto perfo 1∏ Yes	ormed?   c	orior to completion of cause of death? I □Yes 2 □ No
or Vital		Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only		
<u>-</u>	Physician: this certific ral director,	ToE	1  Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier		4 Mursing	Home 5 Resi	dence 6 Oth	er (Specify)
o L			27. Mapmer of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wor		28d. Describe	how injury occurr	red
Sio	Attending r death. ector: After oy the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	28e Place of injuny	At home farm str		Yes 2 □ No	28f Location /	Street and Numb	er or Rural Route Number,
Division	l or Attendafter death Director:	Certification:	4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	Specify)	eet, factory, office		City or To		er or nural noute (variiber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy.  Check only 2 Medical Exam	sician: To the best of m	ny knowledge, deat	n occurred at the ti	me, date and place	e, and due to the	cause(s) and ma	anner as stated.
	the H in 24 the Fi	Medical	one	and manner stated				oneu at the time		
	To To I	Σ	29b. Signature and title of certifier	1 1		29c. Licens				d (Month, Day, Year)
	1050		Jd 16.111	eluch,	My)		9294		rebruar	y 27, 1008
	0.24		30. Name and address of person who co	· ·			thoreh	MD 2	18 <b>7</b> 9	
	Sta	te	John/R. Melaich, M 31. Daye filed (Month, Day, Year)	On Delintrovia	Russell .		Liner Soul	.g, ED 20	5019	
	Regist		MAR 0 5 20	108 Klacia	signature	one is				

Registrar DHMH 17 Rev 1/2001

			Please Type or Prin							•	
			1 - State of Ma	ryland /	-	artment of F <i>rtificate of</i> a		Mental Hy	•	0000	กลลจก
		=1	Registrar     Decedent's Name (First, Middle, Last)			incate or	Death	2. Date of D			3. Time of Death
	Physici /Medic		William Joseph Ba	rton				Month 03	0 6	Y - 200	8 11: 40 pm
	Examin	er	4a. Facility Name (If not institution, give street and number)	110		4b. City, Town, o	Location of Deat	h	4c.	. County of Dea	
8	Funeral	-20		(In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth		thplace (State or Foreign
- T	Director			91	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D 3/5/19	916	Ne	ountry) eW York
	ow ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
	thin 72 hours after death with the Maryland e. "natural", or items 23a or 28a-f show Medical Examiner must be notified at	ctor	Maryland Wicomico	Sali	sbur	У					1 X Yes 2 □ No
	with th a or 28 be no	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	ountry?
	Jeath must	Funeral	711 College Lane, Apt. 2	ver in U.S.	13. \	21804 Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or N	US o-	14. Race - Ame	erican Indian,
٥	after o		1 Never Married 2 Married Armed Forces?	0		f Yes, specify Cuba 1 □ Yes 2 ☑ No	an, Mexican, Puèr Specify:	to Rican, etc.)		Black, Whit	e, etc.
5-0036	hours tural", al Exa	d by	3 Wildowed 4 Divorced Year or Dates:	Army		dent's Usual Occur			16h V		white
را د		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+		(Give life. L	kind of work done  OO NOT use retired	during most of wo. d)	rking	160. K	ind of Business	rindustry
7 7	E de i vii	Com		<u>'  </u>	ma	nager				tail cl	othi <b>n</b> g
and	e d d d	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Harry Barton				18. Mother's Nar Katie l	1 ,	e, Maiden	Surname)	
5	2 should and Mer is marke aumatic	2	19a. Informant's Name/Relationship (Type. Print)	1	19b. Mailin	g Address (Street		<del>_</del>	ber, City o	or Town, State,	Zip Code)
, Mai	s 1 and 2 should if Health and Me item 27 is mark other traumatic		Christine B. Quinn/daughte	r	225	Canal Pa	ark Dr.	#13, Sal	isbu	ry, MD	21804
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1   Barrial 2 □ Cremation 3 □ Removal from State	ceme	etery crer	sition (Name of natory or other place	ce)	Date	l	ocation - City or	,
			4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licentsee	05 1		onal Ceme		·		alisbur	
ğ	permit. Departr Importa any Inji	, I	16th K Stune C	csp		Holloway 501 Snow	Funeral Hill Rd	Home Pr	ofes	sional , MD 21	Association 804
ı	82		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	the death. D							Approximate Interval Between
	Physician			IRA		~ /	PNRU.	monin	7		Onset and Death
	/Medical Examiner		Due to (or as a	consequence LHR	ce of):	70%	DRSE.	1-18			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			<i></i>	WK314	73/2			
	e executed ian and ırial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a		5):						
Ď,	0 0 =	_	bue to (or as a	consequent	ce oi):						
98/9	ician: The law requires that the death certificate be certificate has been signed by the attending physicia rector, page 2 should be detached for use as the bur	Physician/Medica	d								
X Q Q	ath cer ttendir or use	an/N	IF FEMALE:   23b. Was decedent pregnant   23c. If yes, outcome p   in the past 12 months?   1 □ Live birth 2	2 ☐ Fetal déa	ath 3□	Ectopic pregnancy	y		1	23d. Date of de Month	livery Day Year
	the de y the a ched f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ime of death	n 5L	Other (specify) _					54,
S,	requires that the een signed by th nould be detache	by Pr	Part II. Other significant conditions contributing to death but	t not resulting	g in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
cord	require een się nould b	ted						1	Yes 2	<b>5</b> 446 3□P	robably 4 □Unknown
ပ္ပ	The law ate has be bage 2 sh	Completed							s an opsy formed?_	24b. Were a prior to death?	utopsy findings available completion of cause of
VITAL	an: The tifficate or, pag		25. Was case referred to medical				26. Place of De	1□ Yes	2 <b>2</b> No	1 ☐ Yes	2 2 No
_	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien	nt 2 ER/	Outpatien	t 3 DOA Oth	OF:	forme 5 ☐ Res		6 □Other (Spe	ecify)
0 0	iding Physician: h. Heter this certification funeral director,		27. Manner of Death 28a. Date of Injury Natural 5 ☐ Pending (Month, Day		b. Time of Injury	Wor	k?	28d. Describe	how inju	ry occurred	
ISION	Attend death ctor: ,	licati	2	ry - At home,	, farm, stre		Yes 2 □ No	28f. Location	(Street ar	nd Number or R	ural Route Number,
2	s after at Dire	Certification:	4 Homicide determined building, etc.	(Specify)				City or To			,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier (Check only  2 Medical Examiner: On the basis of	examination	dge, death and/or in	n occurred at the til vestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s e, date an	) and manner a d place, and du	s stated. e to the cause(s)
	o the vithin 2 o the omple	$\geq$	one) and manner stat  29b. Signature and title of certifier			29c. Licens	e number		29d. Da	te signed (Mon	th, Day, Year)
)						D	20584	10		02 - 2	3-08
	Oh		30. Name and address of person who completed cause of de	ath (Item 23	a) (Type,	Print)	2 00	0			
Į.	Sta	te	31. Date filed (Month, Day, Year) 32. Restra	STA r's Signature	7/	TOSPICI	E V.	130× 17	33	SAUI.	212h ms 51805
	Registr	ar	30. Name and address of person who completed cause of de  CHUMM WAR'S COA  31. Date filed (Month, Day, Year)  MAR 0 5 2008  32. Resistration	مر معلا	O. A.	good -					

DHMH 17 Rev 1/2001

State Registrar

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DHMH 17 Rev 1/2001

JOHNSHOPKINS HOSPITAL 600 N. Wolfe Street, Bultimore, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

LIZA TAN THE

MAR

10

31. Date filed (Month, Day, Year)

the burial-trar signed by the attending physician be detached for use as the buria page 2 funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

this certificate

After

within 24 hours a

or Attending Physician;

Completed by

Be

Certification: To

Medical

23b. Was decedent pregnant

9 ☐ Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

IF FEMALE:

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death 9□Unknown 5 Other (specify)

3 Ectopic pregnancy

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No

Year

23d. Date of delivery

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRAL PALSY

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 X Natural

5 ☐ Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day

28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death Check onl one

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

autopsy

2 X No

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 ☐ Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

anna

D54004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHANNA, SHIV C., M.D., 1221-E NATIONAL HIGHWAY, LAVALE, MD 21502

State Registrar



DHMH 17 Rev 1/2001

Division or Vital Records. P.O. Box 68760 this or Attending death. after death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 8:30 ам 2008 Fay Berger March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Nursing&Rehab Center Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔼 F Director 061-22-1391 100 12/25/1907 Russia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Md.Howard Columbia 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10842 Faulkner Ridge Circle Funeral 21044 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify þ Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Feinberg unknown Hannah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Obermeyer/Daughter 10842 Faulkner Ridge Circle Columbia, Md. 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Wellwood Cemetery 3-6-2008 Long Island, New York 21. Signature of Funeral Service Licens 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. GASTRODITEMINAL Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPOTHYROIDISM 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 7 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 102 30. Name and address of person who comp cause of death (Item 23a) (Type, Print) KNOLL N DRIVE, COLUMBIA WARTHAL 31. Date filed (Month, Day, Year) State MAR 0 6 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav GEORGE RYDOLPH BROWN 2008 MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOS PITAL CENTER

7. Age (In yrs. last birthday) If Under 1 Year Months Days HESTERTOWN If Under 24 Hrs. | 8. Date of Birth HESTER RIVER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**⊠**M 2□F Hours 216.14.9714 Director MI Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 No Director XENT MD ChESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8905 GEORGE TOWN Kd 216 20 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1944 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 10 Olies Office KENT Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If Item 27 Is marked ပ DEATRICE MMAD HEMRY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POROTHY Brown-WITE 8905 GEORGETOWORD CHESTER TOWN, Md 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ASBURY United MEthodist 3/8/2008 CHESTERTOWN, MD

22. Name and Address of Facility KENNEYH WALLEY FUNERAL SERVICE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee alley (WOUDD 6) 821 W. ST. ANNADOLIS, MARSLAND 21401 23a. 13.1. Ent. the disease, or complications that Jused the death. Do not enter the mode of dying, such as cardiac or respiratory rrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): Physician /Medical Examiner Due to (of as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 2 🏻 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Multiple myelone 1 ☐ Yes 2 No 3 Probably 4 Unknown grennism Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No meningiams autopsy BBU 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Donatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar HEEDERICK

31. Date filed (Month, Day, Year)

X

DHMH 17 Rev 1/2001

6602 Church Hill Rd Chestretown md 21620

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** William E. Coherd 5:44 A M Z /Medical 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5. Social Security Number Battmore FUnder 1 Year | If Under 24 Hrs. | Min. Hedical Center Maryland 8. Date of Birth (Month, Day, Year) Oct. 12, 1932 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1M 2□F Months 577-42-1323 75 Washington, DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f shov ner must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4502 Gridley Road 20906 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 ☒ No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 'natural", Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Menta Edwin W. Coherd Estelle Yendell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Ann Coherd/Wife 4502 Gridley Road, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State permit. Pages Department of Important: If Its any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 6, Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Olan 500 University Blvd., W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adeno carcinoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) the attending physician by Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Inknown progressive dysphagia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? chemotherapy SIP and I or Attending Physician: after death. completely filled in by the fur eral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

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for C. Nort work (FIED)

To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) David Edward Scharff Such Greene Street 31. Date filed (Month, Day, Year) MAR 0 5 2008

32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Baltimore, MD

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** LEW GARRISON COIT, JR. Feb 29 2008 5:48 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Easton Talbot If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F Director MINNESOTA 81 OCT 27,1926 579-38-6180 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County 28a-f sh notified 1 ☐ Yes 2 No Funeral Director TALBOT OXFORD MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 26592 EAST BONFIELD ROAD 21654 USA 'natural', or items dical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married Married 1 Yes 2 □ If Yes, Give Year or Dates: 2 No Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Completed by 3 Widowed 4 Divorced WHITE Department of Health and Mental Hygiene. "natur Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) OFFICER CIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be LEW GARRISON COIT, SR. ပ ELIZABETH AGNES GRAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MATZEN COIT/WIFE 26592 EAST BONFIELD ROAD, OXFORD, MD 21654 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JAMES CEMETERY 3/11/2008 LOTHIAN, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee Joseph Ostavshi C.f.SP M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks **Physician** /Medical Due to (or as a consequence Examiner months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed burial-tra P.O. Box 68760, physician the attending pl IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24a. Was an autopsy performed?

1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 🗌 Yes 2 No death. 2 Accident l or Attend after death Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) . Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+14 31. Date filed (Month, Day, Year) State MAR 05 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 5:30 A 02 28 2008 /Medical une 4c. County of Death 4a. Facilify Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Salisburi Wicomico at the If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🙀 F Hours 10/14/1947 60 Director 213-52-5698 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show Yes 2 No ral", or items 23a or 28a-f sh Examiner must be notifled Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Baltimore, Maryland 21215-0036 ${\it Calo}$ Funeral 21804 USA 410 Parkwood Dr. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Completed by White 3 Widowed 4 Divorced "natural". the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M Domestic 12 4+ Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Cunningham P Meredith Crum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Calo/husband 410 Parkwood Dr. Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Hebron 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/3/08 Dagsboro, Delaware Cemetery 21. Signature of Funeral Service Name and Address of Facility Salisbury, MD21804 501 Holloway Funeral Home, Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Tastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to in reculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should certificate has been 24a. Was an autopsy performed.

1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death Check onl Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA this completely filled in by the funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 7

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> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAR 0 5 2008

Date filed (Month, Day, Year)

29d. Date signed (Month, Dav. Year)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: s efter death. within 24 hours e To the Funeral C completely filled i

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29a, Certifier

29b. Signature for certifier

Medical

31. Date filed (Month, Day, Year) MAR 1 0 2008 gistrar's Signature

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1 A Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Mgnth, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death Day Physician /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Birthplace (State or Foreign Country) 24 Hrs. Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕱 F Months Hours Min Yrs. Director 80 161-24-5208 10/5/1927 NJ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits la or 28a-f show t be notified at 1 ☐ Yes 2 X No Director MD QUEEN ANNE'S SUDLERSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a Examiner must b 300 DEER TRACK LANE 21668 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 K If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ WHITE Specify: 3 Widowed 4 Divorced 'natural'; Completed r than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene tem 27 is marked other than **HOMEMAKER** OWN HOME 7 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Į, NEAL SHARP **EVELYN HARRIS** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN W. CLARK/HUSBAND 300 DEER TRACK LANE SUDLERSVILLE, MD 21668 Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State to I ō 1 ■ Burial 2 Cremation 3 Removal from State Department of Important; If any injury of once, 4 Donation 5 Dother (Specify) SUDLERSVILLE CEMETERY3/9/08 SUDLERSVILLE, MD 21. Signature of Funeral Service L 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Par **Physician** Kingon's disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) P.O. Box 68760, physician by Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Tes 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2000 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Nedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D58821 6108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALL DONAHER MD 944 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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			1 - For State Registrar	State of Maryland		artment of He			giené) () {	8 08902
	Physici /Medi		Decedent's Name (First, Middle, Last)     Donald James Da	hlquist				2. Date of De		3. Time of Death 6:41P M
	Examir		4a. Facility Name (If not institution, give stre Montgomery Gener		1	4b. City, Town, or Olney	Location of Dea	ith	4c. County of Di	
	Funeral Director		5. Social Security Number 223-82-4019  Usual Residence of Decedent	7. Age (In yrs. la: 5 4	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		v. rear	Sirthplace (State or Foreign Country) 'irginia
	e-f show	ctor	10a. State 10b. County MD Montgomer		Town or Lo	cation	ge			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28	al Director	10e. Street and Number 14 Meadow Croft	Ct.		10f. Zip Code 20886			10g. Citizen of What USA	Country?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Importent: If item 27 is marked other than *natural', or items 23e or 28e-f show any righty or other traumatic event, if a Medical Exacting true Legicilled at once.	by Funeral	1 X Never Married 2  Married	Was Decedent Ever in U.S. Armed Forces? 1	If	Vas Decedent of His i Yes, specify Cuban	panic Origin? ( , Mexican, Pue <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, W Specify: W	
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	and 2 sho ealth and m 27 is mu	1 3	19a. Informant's Name/Relationship ( <i>Type</i> , Diane Ringer – S	·					r, City or Town, State VA 22032	
Baltimore,	Pages 1 ment of H tent: If ital jury or oth		20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Fair	fax Tax	sition (Name of latory or other place MEMOTIAL HOME	20	cch 7,	20c. Location - City of	VA
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee  Benowth Da	nish	Ho	me 9902	Braddo	ock Rd.	Memorial Fairfax,	Funeral VA 22032
8	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one collimmediate Cause (Final disease or condition resulting in death)	SEPS	i S	ir the mode of dying,	such as cardia	c or respiratory are	rest,	Approximate Interval Between Onset and Death
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or Vital	hys this	: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  1 No  27. Manner of Death	Inpatient 2 EH	VOutpatient	3□ DOA Other:	4 Nursing F		ence 6 □Other (Sp	ecify)
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2	Nospital or Al 24 hours after of Funaral Dirac stely filled in by		4   Hornicide	building, etc. (Specify)			data and alass	City or Town		
	To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	Medical	Z moulcar Examiner:	On the basis of examination and manner stated.	and/or inve	estigation, in my opin	nion, death occu	urred at the time, d	ause(s) and manner a ate and place, and du 9d. Date signed <i>(Mor</i>	e to the cause(s)
ľ			30. Name and address of person who comple	Selection of death (from on	MD MO	D39	9177		12 - 29 -	
,	Stat		CURTIS WOLLAYC  31. Date filed (Month, Day, Year)	- 1	I P	RINCE P	HILIP	DR C	LNEY M	18 20832
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				1. Decedent's Name (First, Middle, Last)	- JB Gei	nnicate of	Death	2. Date of Deat		3. Time of Death
_		Physicia /Medic		Ellen C		Darby		March	4, 200°8	9:20pm
		Examin		4a. Facility Name (If not institution, give street and number)			or Location of Death		4c. County of Deat	
		Europal			yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day,	Somer.	hplace (State or Foreign
		Funeral Director		216-16-7166 1□M 2ĂF	83 Yrs.	Months Days	Hours Min.	June 15	,1924 Ma	ryland
		and wo		Usual Residence of Decedent           10a. State         10b. County         10c	. City, Town or Lo	ocation				10d. Inside City Limits
		the Marylan 28a-f show	ctor	MD Wicomico	Eden					1 ☐ Yes 2 No
		within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f ehow tha Modical Examiliar must be motillisd at	Director	10e. Street and Number		10f. Zip Code	000	1	Og. Citizen of What Co	ountry?
Z		ns 238	Funerai	5010 Cooper Road  11. Marital Status 12. Was Decedent Ever	in U.S. 13.		822 Hispanic Origin? (Spe pan, Mexican, Puerto	ecity Yes or No-	USA 14. Race - Ame	
90	9	or Itan	/ Fun	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No	1	If Yes, specify Cub  1 ☐ Yes 2 No		Hican, etc.)	Black, Whit	-
9:20 PM	5-0036	72 hours after death w "natural", or Itams 23a	ed by	3 Widowed 4 Divorced Year or Dates:		dent's Usual Occu			16b. Kind of Business	nite /Industry
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	N	led wit lygiene har tha		10		Homemak	er 18. Mother's Name	/First Middle	Own Home	
80	anc	d be fi	To Be	17. Father's Name (First, Middle, Last) Amos		Cox	Violet	s (Filot, Mildaio, F		edden
March 4,2008	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural, or Items 23a or 28a-f sho sary injury or other traumatic avant. The Madical Examinational be natilised as one?	F	19a. Informant's Name/Relationship (Type, Print)			1	al Route Number	, City or Town, State,	
7	$\geq$	and 2 lealth a m 27 I		Frank Darby- Husband	5010 bb. Place of Dispo		oad Eden,		2 20c. Location - City or	Town State
4	Baltimore,	Pages 1 nent of H int: If its iry or ot		1 Burial 2 Cremation 3 Removal from State	cemetery, cre	matory or other pla			Hebron, M	
22	altin	permit. P Departme Importani any injury once.		'4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	Hebron C		ess of Facility Bou			aryranu
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	9 X	The law requires that the death certificate I ste has been signed by the attending physi page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pr	egnancy				23d. Date of de	livery
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drby	ds,	signed d be d	by	Part II. Other significant conditions contributing to death but no	t resulting in the t	underlying cause g	iven in Part I.	1 🗆 Y		robably 4 Unknown
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		rsiclan: The law s certificate has t lirector, page 2 s	Completed					autops perfor 1 Yes	med? death?	s 2 No
É	Vital	iclan: certific ector,	Be	25. Was case referred to medical examiner?  Hospital:		_ 10	26. Place of Deat			
	ō	Phys or this oral dir	οב :ר	27. Manner of Death  1 Natural  5 Pending  (Month, Day Yes	2 ER/Outpatie	INT 3LI DOA	4 Nursing Ho		ence 6 Other (Spe ow injury occurred	ecify)
1_4	ion	ttanding F death. ctor: After y the funera	atio	2 Accident investigation	ar) Injury		Yes 2 No			
	Division	or Atti	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	treet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	lural Route Number,
5	3	To the Hospital or Attanding Physiclan: The within 24 hours after death.  To the Funaral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of m	y knowledge, dea	th occurred at the	time, date and place,	and due to the d	ause(s) and manner a	s stated.
6	me	the Ho lin 24 t the Fu	Medicai	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or in					
4	1/2	To To Com	2	29b. Signature and title of certifier  DR 'USH	A		05/359		29d. Date signed (Mon  March 5 ii	
	"	(oni		30. Name and address of person who completed cause of death			7.0-1		March 3	7000
		wgu		1415 . S. DIVISION ST,	SAUSBO	URY IMD	1804			
		Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 5 2008	Signature	00 H 2				

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. "Insportant if item 27 is marked other than "natural", or items 23a or 28a-f show any fultur or other traumstic event, the Medical Examiner must be notified at
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	Exa	mine
	20	r.
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department			giene Reg. No. 2008	08904			
Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death			
/Medic	al	JOHN WILBUR DAVIS	or Location of Death	MARCH	3, 2008 4c. County of Dea	4:00 P M			
Examin	er		CCOKEEK	ı	PRINCE GEORGES				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Birt	9. Birthplace (State or Foreign 27, 1921 MARYLAND				
Director		216-12-4707   X   86   Yrs.   Usual Residence of Decedent		27,1921 FIAR	921 MAKILAND				
aryland show	Ļ	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
the Ma 28a-f s lotifie	Director	MARYLAND PRINCE GEORGES FORT WASHINGTON  10e. Street and Number 10f. Zip Code			10g. Citizen of What C	1 X Yes 2 No			
3a or		12300 LIVINGSTON ROAD 207	44		UNITED STA	•			
r deat	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces? 1  Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - Ame Black, Whi				
ours after death with the Marylar purs atter death with the Marylar al", or items 23a or 28a-f show Examiner must be notified at	by Fi	1	Specify:		Coopifu: -	LACK			
If it is not safer death with the Maryland flied within 72 hours after death with the Maryland Hygiene. Hygiene, ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		15. Decedent's Education   16a. Decedent's Usual Occ. (Specify only highest grade completed)   (Give kind of work done	upation e during most of wor	kina	16b. Kind of Business				
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	To B	JOHN FRANCIS DAVIS	ADA MAR	IE CONTE	EE DAVIS				
12 sh h and rs m		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Stree  MARY MARGARET MANSFIELD/FRIEND  12300 LIVINGS'				. ,			
t an deal deal deal deal deal deal deal deal		20a. Method of Disposition 20b. Place of Disposition (Name of	1	Date	20c. Location - City of				
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200		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death			
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con Grantino Action (Con	ナイナーク	TUNE	We,	X Man for			
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recuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
ificate be executed physician and as the burial-transit		Bab to (or as a sensequence et).							
# D.E	<b>Aedical</b>	IS SEAMLE.	***						
The law requires that the death cert is the has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnan	су		23d. Date of de Month	Day Year			
the de	ysic	1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown							
res that the de signed by the a	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	iven in Part I.	23e. Did to	obacco use contribute	,			
w require been signature				10'	Yes 2□No 3□F	Probably 4 Onknown			
has by	Completed			24a. Was autop perfo	an 24b. Were a prior to death?	autopsy findings available completion of cause of			
		25. Was case referred to medical	26. Place of Dea		2 <b>10 N</b> Jo 1 □ Ye				
Physician: this certifica	То Ве	examiner?  1 Yes 2X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA O	thos		dence 6 XIOther (Sp	GROUP ecify) HOME			
Jing Ph After th funeral		Tatvatural 5 Feriding	uryat ork? ⊒Yes 2 ⊒No	28d. Describe I	how injury occurred				
Atten r death ector: by the	Certification:	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office		28f. Location (S	Street and Number or F	Rural Route Number,			
ital or rs after ral Dir	Cert	building, etc. (Specify)		City or Tou					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)			
To the to the company of the the the the the the the the the the	M	29b. Signature and title of certifier 29c. Licer	206	29	29d. Date signed (Mor	th, Day, Year)			
136		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	JALDON	F, M	cl 206	012			
Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 6 2008  32. Registrar's Signature							

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

To the roots after deam.

To the Funeral Director: Af

fo the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ence of):	dial Infare	how		Onder and Board
icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent).  Due to (or as a consequent).	, 	allera			
iysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes MRNo 9 □ Unknown	3c. If yes, outcome pf pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □ Ectopic			23d. Date of det Month	ivery Day Year
ed by Fi	Part II. Other significant conditions con dementica, h Chronic arth			cause given in Part I.	23e. Did tobacc		o the cause of death?
Comple	Chronic arth	citis pau			24a. Was an autopsy performed 1 Yes ►	? prior to death?	topsy findings available completion of cause of 2 ☐ No
מ	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
5	1 ☐ Yes ♣️ No	lospital: 1 ☐ Inpatient 🗷	ER/Outpatient 3□ [	OOA Other: 4 Nursing I	Home 5 ☐ Residence	e 6 □Other (Spec	cify)
ation:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Ser III C	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, street, facto )	ory, office	28f. Location (Street City or Town, St		ural Route Number,
anical	29a. Certifier (Check only one)  Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death occurre ion and/or investigati	d at the time, date and plac on, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
IVIE	29b. Signature and title of certifier	K	2	9c. License number D46940	29d.	Date signed (Month	h, Day, Year)

State

Registrar

3H-4

Ivania Avenue Hagerstown MD 21740

30. Name and address of person who commetted cause of death (Item 23a) (Type, Print)

W. E. Kutzera 31. Date filed (Month, Day, Year)

MAR 1 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per verb., g877,03/25/08dhb Reg. No. 0000 008 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month PAULA **EDMONDS** March 0805 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital@ EASTON TALBOT ASTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 1 □ M 2 🔀 F Months Days Hours 93 099-10-5927 **NEW YORK** SEPT 17,1914 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No TALBOT WITTMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22710 EMILY'S LANE 21676 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWARD KURFNER PAULA KERSCHBAUM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIE LICHIOVERI/DAUGHTER 22710 EMILY'S LANE, WITTMAN, MD 21676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PINELAWN MEMORIAL PARK 3/6/2008 PINELAWN, NEW YORK 22. Name end Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licenses F.SA Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NGESTIVE disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2**√**2 No 3 Probably 4 ☐ Unknown EUMONIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes 26. Place of Death (Check only one) Inpatient 2 ER/Outpatient 3□ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

\$

Completed

Be

2

10a. State

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more.

Examiner

Physician/Medical

IF FEMALE

burial-transit physician and signed by the been has this certificate

The law requires that the death certificate be executed After t

O. Box 68760 σ. Records, Division or Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

> State Registrar

by Completed 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier var rem

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. OBAYOMI

31. Date filed (Month, Day, Year) MAR 04 2008

STREET

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 200g /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** KIVE 1 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 ☐ F Director 87 212-03-2868 4/20/1920 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD 1 XYes 2 □ No Director KENT CHESTERTOWN 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 100 S. KENT 21620 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: **WWII** 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo WHITE Specify: þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 FURNITURE SALESMAN and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be JAMES EVERETT MAMIE WELLER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau NANCY THOMAS/DAUGHTER 116 JIM JUNGLE RD. MILLINGTON, MD 21651 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¹**K** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CHESTER CEMETERY 3/10/08 CHESTERTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Auch 23a. Part1. Enter the disease, or comilications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one come each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Artero Scherotic Cardio Vescular Discese >104eav 3 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the as IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by VA & BHemiporalysis! Feriphoval Vasculor Discuso 1 Yes 2 No 3 Probably 4 Unknown DM TypeH, HTN, CKD, Achol PTG. 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No page certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 200 No ဥ 1. Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1. Natural 5 ☐ Pending investigation Injury thin 24 hours after death. the Funeral Director: A mpletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

the

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29c. License number

0050996

29d. Date signed (Month, Day, Year)

and manner stated.

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32. Regis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 0 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year March 2, 2008 Wilburn W. Frazier 11:45 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery Social Security Number 344-05-2857 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10℃ M 2 🗆 F Yrs. Director 93 July 20, 1914 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Illinois Madison East Alton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23e or 451 Sullivan Avenue 62024 USA Funera tems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. withIn 72 hours after 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Media 2002. Elementary/Secondary (0-12) College (1-4or 5+) 10 Foreman Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira Frazier Ella Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Laura Frazier/Wife 451 Sullivan Avenue, East Alton, IL 62024 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 11, 20c. Location - City or Town, State 1 SpBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Rose Lawn Memory Gardens 2008 Bethalto, Illinois 21. Sign ture Tuper Service Livens e 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd., W., Silver Spring, MD 20901 10Men 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypoxic Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physicien: The law requires that the death certificate be executed sician and e burial-tran Due to (or as a consequence of) Box 68760, Completed by Physician/Medical attending phys the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery Live birth 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 KMinknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2□ No 1 Yes 2x No of Vital director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐xNo 1 StInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation TX Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide 5 within 24 hours a

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completely filled **Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) hm anian D66372 March 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Majid Rahmanian, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	Examir	er	4a. Facility Name (If not institution, give street and 49 Charbon Lane	i number)		North F	Location of Death		4c. County of Cecil				
2.7	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	rth 9. Birthplace (State or For				
в	Director		002 <b>–</b> 38 <b>–</b> 1856 ¹ X м ² □	F 60	Yrs.	Months Days	Hours Min,	(Month, Day Aug. 18		Country) Massachusetts			
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Ω̈́	all or / after I Dire d in b	erti	4 ☐ Homicide determined b	uilding, etc. (Specif	y)	,		City or Tow	n, State)	,			
	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To (Check only 2 Medical Examiner: On t	the best of my kno	wledge, deat	occurred at the tim	ne, date and place,	and due to the o	ause(s) and mann	er as stated.			
	the H nin 24 the F nplete	Medical	one) and	manner stated.									
	7. Viii	2	29b. Signature and title of certifier	1		29c, License	number	1	9d. Date signed (/				
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\	5+1VA		30. Name and address of person who completed	cause of death (Item	h [7	Site 1	714 5/1	ton. r.	10 219	21			
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7	hysik this ca al dire	2	1 Yes 2 No	Hos	spital: 1 ☐ Inpatie		ER/Outpatien			4 🗀 Nursing	Home 5₺ Re		. ,	ecify)		
U.	ing P	ü	27. Manner of Death 1 <b>述</b> Natural 5	Pending	28a. Date of Inju (Month, Day	ry v Year)	28b. Time of Injury		28c. Injury Work		28d. Describe	how inju	ury occurred			
Sic	Attending Physician: The prideath. Tector: After this certificate he by the funeral director, page	icat	2 ☐ Accident 3 ☐ Suicide 6	investigation Could not be	28e. Place of inju	iny - At ho	me farm str	M eet fact		Yes 2 □ No	28f Location	(Street a	and Number or F	ural Boute Num	her	
Division or Vital Records,	efter death	Certification:	4  Homicide	determined	building, etc	. (Specif	y)	eet, lact	ny, onice		City or To			arar rioute rearr	uei,	
	To the Hospital or At within 24 hours after of To the Funeral Office completely filled in by		(Check only 2 🔲	Certifying Physic Medical Examine	r: On the basis of	f examina									i)	
	o the ithin 2 o the I	Medical	29b. Signature and title		and manner sta	ated.			9c. License				ate signed (Mor			
	7-		> Chih	: les	van. O				D42				ch 04,			
,	V		30. Name and address of	of person who com	eted cause of de	eath (Item	23a) (Tvpe.	Print)	5-76	7.5		iidi	CH 04,			
			Dr. Chitra						enter	Drive #	221, Ro	ckvi	lle, MD	20850		
	Sta Registr	_	31. Date filed (Month, D	0 5 2008	32 Registra	ar's Signa	ture	all I								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 UU3 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year **Physician** March Robert 4, 5:50A. M Geier /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Renaissance Gardens at Riderwood Village Silver Spring If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April9,1924 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 83 104-14-9174 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Mərylənd Prince George's Silver Spring 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3144 Gracefield Road,#GV419 20904 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 XYes 2 No If Yes, Give Year or Dates: Unk. 1 ☐ Never Married 2 X Married 1 □ Yes 2 PNo Baltimore, Maryland 21215-0036 Specify. Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Communications U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Geier Minnie Dorf ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nettie M. Geier -wife 3144 Gracefield Road, #GV419 Silver Spring, Md.20904 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State Metropolitan Crematory 3/4/2008 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Bonald Word Borg Wardt Funeral Home, PA U 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 Week Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Parkinson's Disease 10 years Sequentially list conditions, flamy, leading to infine did cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2√ No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and the of con-29c. License number 29d. Date signed (Month, Day, Year) D24093 March 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 5

2008

Mark Parkhurst, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Tilghman Lester German Jr. February 8-50PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALSbury
If Under 1 Year If Under 24 Hrs. Mil Dimil D MILDMILD Nursing Itome 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1**⋤** M 2□ F 215-20-1407 Director 82 11/11/1925 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Director Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 606 Crestview Lane 21801 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Army 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 master machinist/sales manager engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tilghman Lester German Sr. Ethel Fields ortant: If item 27 Is marke injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah German/wife 606 Crestview Lane, Salisbury, MD 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hebron Cemetery 3/4/08 Hebron, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association CESP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCYD Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, bisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) a□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specity) Hospital: 1 ☐ Yes 2 ☐ No JO. 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No I Director; 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

COLIVE Sy

> State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

and manner stated.

ess of person who completed cause of death (Item 23a) (Type, Print)

D

egistrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

EASTERN Shore Du

29d. Date signed (Month, Day, Year)

MD 218X

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 0.0.2

			For State Registrar	State of Mary		rtificate of D			J. No.	00210			
		*	1. Decedent's Name (First, Middle, Las				2	Date of Death Month	Day Year	3. Time of Death			
	Physici /Medic		MARGARET	W. GROZI	INGER			ARCH 4	2008	7:45 P ^M			
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or L			4c. County of Death	. T. O. I.			
4	Allen a co		WILSON HEALTH CAR  5. Social Security Number 6. Se		yrs. last birthday,	GAITHERS		Date of Birth	FREDER				
	Funeral Director			M 21√2 F	97 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, )		place (State or Foreign ntry) GINIA			
	yland		10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits			
	Mar Be-f st	ţ	MD FREDERI	rck	GAIT	THERSBURG			1√ Yes 2 No				
	or 28	Olre	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?			
	ath w	la	201 RUSSELL AVENU			2087	<u> </u>		USA				
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or itams 23a or 28a-f show event, Ita Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2√√No	panic Origin? (Specit , Mexican, Puerto Ric Specify:	iy Yes or No- can, etc.)	No-  14. Race - American Indian, Black, White, etc.  Specify: WHITE				
8	tural	edt	15. Decedent's Edi			dent's Usual Occupat	ion	16	6b. Kind of Business/Ir				
21215-0036	- 4	Completed	(Specify only highest grad	de completed)  College (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	iring most of working			,			
21	filed within ' Hygiene. ther then "I	mo.	Elementary/Secondary (0-12)	4	PA	YROLL SERV	ICES		FINANCIA	4 L			
	be filed lat Hygir d other	Be (	17. Father's Name (First, Middle, Last)			1	18. Mother's Name (F						
yla	should be filed within and Mental Hygiene. I marked other than umatic event, the Mental Control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental	၉	HARRY VINCENT WHE						T SANDERS				
Maryland	d 2 g th ar trau		19a. Informant's Name/Relationship (T) MARGARET GARDNER			_			City or Town, State, Zi, LE, MD 2163				
	s 1 an of Heal item 2 other		20a. Method of Disposition	.2	0b. Place of Dispo		Dat		Oc. Location - City or T				
E O			1 ☐ Burial 2√ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	•	G CREMATORY	3/9/20	800	SMITHSBUR	G. MD			
Baltimore,	permit. Page Department Importent: if any injury o		21. Signature of Funeral Service Licens			2. Name and Address			_ HOME, P.O.				
8	82 = 8		Charles M.	Blown		327 W.KING	G ST., MARTI						
28			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.	death. Do not en	ter the mode of dying,	, such as cardiac or r	espiratory arres	st,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Cerebr	Kluservo	- Acad	ent			Oriset and Death			
1	/Medical Examiner		resulting in death)	Due to (or as a co			1						
В		70	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nsequence of):								
	nsit	nlne	Cause (Disease or injury	Due to tot as a co	nisequence ory.								
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):								
68760,	rtificate be executed ng physician and as the burial-transit			d									
		Physician/Medical	IF FEMALE:										
Вох	eath cerr attendin for use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of po 1 ☐ Live birth 2 ☐	Fetal death 3[	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year			
-	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown	of death 5[	Other (specify)							
P.O.	res that the de igned by the a be detached f	h h	Part II. Other significant conditions co	ntnbuting to death but no	ot resulting in the u	Inderlying cause given	n in Part I.	23e. Did toba	cco use contribute to t	the cause of death?			
Records,	De De	d by						1 ☐ Yes	2 □ No 3 □ Pro	bably 4 JUnknown			
Ö	w requires been si	Completed						24a. Was an	24b. Were auto	opsy findings available			
Re	The lav	шо						autopsy performe	ed prior to co	ompletion of cause of			
ita		0	25. Was case referred to medical				26. Place of Death (			2010			
<u>_</u>	S S S	To B	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	nt 3 DOA Other	4 Nursing Home	5 Residen	ce 6 Other (Speci	(y)			
Division of Vital	ing Ph Viter th uneral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Work?		d. Describe how	v injury occurred				
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				es 2 No						
N.	or Attendated of the or after deat Director:	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, sti pecify)	reet, factory, office	281	City or Town,	eet and Number or Rur State)	ai Houte Number,			
hand.	spital ours neral filled		29a. Certifier 1 Certifying Phy	sician: To the best of m	v knowledge, deat	h occurred at the time	date and place, and	d due to the cau	ise(s) and manner as	stated			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer	edical	(Check only 2 Medical Exami	iner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my opin	nion, death occurred	at the time, dat	e and place, and due t	to the cause(s)			
	To tro	Σ	29b. Signature and title of certifier			29c. License		290	d. Date signed (Month,				
			1/2/10	ohn		D.	20148		> Marci	n 2008			
			30. Name and address of person who co	1 1 - 000		Print) Duscant	1 Ave.	Gath	rishing M	201			
	Sta	te.	31. Date filed (Month, Day, Year)	32. Pegistrar's		1 1003561	1 INC.	O 701 W 30	LIBUIS II	10,			
	Registra	400	MAR 1 9 20	2007	K A	20000							
		_		1980 300 300	- 34	Street Walter St.							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 4,2008 **Physician** Hochheimer Hella March 6:55p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Wash. Rockville Montgomery 7. Age (In yrs. last birthday) Il Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 3/21/1919 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🗓 F Germany 521-34-6061 88 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinar must be excitited at Rockville 1 ☐ Yes 2 No Completed by Funeral Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 20852 11905 Old Bridge Road USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
int: if itsm 27 is marked other then "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔥 No Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: 3 ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done de life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Basch Hubert Kolker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11905 Old Bridge Road Rockville, Md 20852 Jean Hochron/Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 Ki Removal from State permit. Page Depertment of Important: if sny injury or once. Cedar Park Cem. 3/06/2008 Paramus, New Jersey 4 □ Donation 5 □ Other (Specify) 21. Signatu 4.7 Funeral S. (vic.) Licensee BHTLTPAdos RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MENTIA OF ALZHEIMERS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): To Be Completed by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown cete has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 1 or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes & No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funerel Director: / completely filled in by the f 6 ☐ Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 ☐ Homicide Hospitel To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who-completed cause of death (Item 23a) (Type, Print) 112058 Mn. 31. Date filed (Month, Day, Year) 32. Signature State

Registrar

**MAR 0 5** 

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 9:00 A Frances Clare Hannan March 3. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1900 Lyttonsville Road #415 Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 T F Director 493-32-0845 Feb. 28, 1931 Washington, DC Usual Residence of Decedent r 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits Director MD 1 XIYes 2 □ No Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be 1900 Lyttonsville Road #415 20910 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 ANO Specify: White Completed by 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager with AT&T Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Hannan Amy Clare O'Toole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Step-Brother Robert C. Minor/ 4100 Sycamore Street, Chevy Chase, MD. 20815 If item 27 or other t Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State March 4, 2008 Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Function Service Licenses 22. Name and Address of Facility DeVol Funeral Home Min 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer of Unknown Primary Source /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Divisito for es a nonsequenne offi-Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Tagesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 Physician:

death with the Maryland

filed within 72 hours after

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Maryland 21215-0036

Baltimore,

attending pl for use as t à pe page 2 director, this After or Attending death 24 hours after death e Funeral Director: filled in by Hospital the

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9a. Certifier (Check only one)  1   Certifying Physician: To the best of my knowledge, death occulum (Check only one)  Comparison of the basis of examination and/or investigated and manner stated.		
9b. Signature and title of certifier /	29c. License number	29d. Date signed (Month, Day, Year)
Db. Signature and title of certifier www blowski W	D0064615	March 03, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski M.D. 1355 Piccard Drive, Rockville, MD. 20850

State Registrar

Medical 2

> 31. Date filed (Month, Day, Year) MAR 0 5 2008



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician EVELYN** BARCUS HALL 29, 3:55 P M FEB. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 24, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖫 F Yrs. 81 Maryland 577-36-7198 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show ns 23a or 28a-f shov must be notified at 1y Yes 2 □ No Director Gaithersburg Montgomerv 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20882 U.S.A. 7600 Brink Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner man 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 █**X**No Specify: Specify: Black 2 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery Co. tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bus Operator Public Schools 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Hawkins John Barcus ပ 19a. Informant's Name/Relationship (Type. Print) (Daughter) (Daughter) (Daughter) of Health if item 27 i Rosemere Ave. Silver Spring, MD 20904 608 Carolyn A. Williams 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iter any Injury or ott once, Pages ' ▶ Borial 2 Cremation 3 Removal from State Arlington Nat'l Cem 3/18/08 Ft. Myer, VA 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. grate of Funeral Service 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Failure Respiratory Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending ph for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2X No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Infected Decubitus Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an End Stage Kidney Disease certificate has b irector, page 2 s autopsy performed? Yes 2 140 Hypotension the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 TYes 1XX Inpatient Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dicompletely filled in 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) MAR 0 5 2008

WITTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

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29c. License number

D064100

29d. Date signed (Month, Day, Year)

3/2/08

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 2000

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-	Funeral	2.15	5. Social Security Number	Nursing I		last birthday)	Salis If Under 1 Year		8. Date of Bir				oreian
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	tems er m	Funeral	11. Marital Status	12. Was Deced	ces?	l.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14	4. Race - America Black, White,		
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Dallinor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	e Licensee	Mile		. Name and Addres	. D	ounds F			1 0100/	
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2	r Atter	Certification:	3 ☐ Suicide 6 ☐ Could	minod Zoe. Flace	of injury - At ho g, etc. (Specii	r ome, farm, stre fv)	eet, factory, office		28f. Location (	(Street and wn, State)	Number or Rura	l Route Number,	5
2	urs aft eral Di												
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of the base of	sis of examina	owledge, death ation and/or inv	n occurred at the time vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) a , date and p	and manner as st place, and due to	ated. the cause(s)	
	To th within To th comp	Ž	29b. Signature and title of certifi	er			29c. License	number 3/99		29d. Date	signed (Month, I	Day, Year)	
	(1000		Mark	NU			_   V 6.	<i>S</i> ()   .		03/0	5/2008	4	
	480		30. Name and and uss of person				·				24.00 *		
	Sta	te.	Yogesh Vo	hra M.D.	614 #strar's Signa		rnshore	_Dr Sal	isbury	7 MD	21804		
	Registr		MAR 0	5 2008			Socrats &						

DHMH 17 Rev 1/2001

# Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State	riease iy	•		d / Depa	rtment of H	lealth and	Mental Hy	giene		00021
		Registrar				Cer	tificate of	Deam		Reg. No 🛴 👃	08	00021
Physici /Medic		1. Decedent's Name (Fire Donald L							2. Date of Dea	Day	0 S	3. Time of Death
Examin	ier i	4a. Facility Name (If not i	institution, give str	reet and numi	ber)	^ .	0 0 1	r Location of Deatl	h		y of Death	
		reninsula.	Regional	Med	lical (	emer	Salish	en		WI	Comic	0
Funeral		5. Social Security Number	. No./		. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h v. Year)	9. Birthp	place (State or Foreign
Director		178-24-788	4	M 2□F	75	Yrs.			Sept.22			nsylvania
pu ,		Usual Residence of Dece			10c City	, Town or Lo	nation					0.1.1.1.1.0.1.1.1.1.1.1.1.1.1.1.1.1.1.1
anyla shov d at	<u>-</u>		. County		Toc. Oil	, TOWITOT LO	cation					0d. Inside City Limits 1 ☐ Yes 2 M No
Ba-f	5	DE	Sussex		] ]	Dagsbor	ro					TI TES ZINO
or 2	Funeral Director	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Cour	ntry?
23a ust b	ra	30814 West	Lagoon	Road			199			U.S		
ems er m	lue	11. Marital Status	12	2. Was Deced Armed Ford	lent Ever in U. ces?	S. 13. V	Was Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Ra	ce - Americack, White,	
or it	Ę	1 Never Married		1 Yes 2 If Yes, Give	2 □ No		Yes 2 No	Specify:	,	Speci	7.71	ite
ural",	d by	3 ☐ Widowed 4 ☐ I	Divorced	Year or Dat	tes:							
72 h 'natu dica	Completed	15. 1 (Specify or	Decedent's Educa nly highest grade	ition completed)		16a. Deced (Give	lent's Usual Occup kind of work done DO NOT use retire	ation during most of wo	rking	16b. Kind of B	Business/In	dustry
ithin han e Me	ם	Elementary/Secondary	y (0-12)	College (1-	4or 5+)						_	
ed w lygie lygie rer tl	ខ					Fre	eight Con			Rail		
be fil tal H d oth even	B B	17. Father's Name (First,						18. Mother's Nar	ne (First, Middle,	Maiden Surna	me)	
Men Men arke	၉	Wilmer F.	Kemper					Eliz	abeth (W	atson)		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 25a or 28a-f show raumatic event, the Medical Examiner must be notified at		19a. Informant's Name/F		,		19b. Mailin	g Address (Street	and Number or Ri	ural Route Numbe	er, City or Town	n, State, Zip	Code)
and ealth n 27 eer tr		Eileen M.	Kemper	/ Wife			West La	goon Roa	d, Dagsb	oro, D	E 1993	39
of H of H fiter roth		20a. Method of Disposition 1 ☐ Burial 2 🗶 Cree		moval from S	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other pla Shore	ce)	Date	20c. Location	- City or To	own, State
Pag nent ant: I		4 □ Donation 5 □			Late F. &	Crema	snore storium	Mar.	4,2008	Lewes	s, Del	laware
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	Service icensee	X		22	Name and Addre	ss of Facility <b>Funeral</b>	Entorpri	202 T		
9 5 5 6		3	Tel or	Lell)			Rts. 26	& 17, C1	arksvill	e, DE	19970	
1 7 7 3 3		23a. Part1. Enter to dis shock, or hear fail	sease, complica	ations that ca	used the death	. Do not ent	er the made of dyin					Approximate Interval Between
Physician	ш	Immediate Cause (Final		Cause off ea		- 1	1000	1				Onset and Death
/Medical		disease or condition resulting in death)	a.	Due to (o	r as consequ		thack				-	
Examiner	ш			-	0	.0	Park	10			- 1	
	ē	Sequentially list condition if any leading to immediate	ns, b.	Due to o	r as a conse u	uence of	7	,,,				
uted Insit	Examine	Cause (Disease or injury										
be executed ician and burial-transit	xa	that initiated events resulting in death) Last	C.	Due to (o	r as a consequ	uence of):					-	
	call											
w requires that the death certificate been signed by the attending phys should be detached for use as the			u.									
certi	Physician/Medi	IF FEMALE: 23b. Was decedent pred	anant 23		ome pf pregna					23d D	ate of deliv	erv
eath atter	cial	in the past 12 mon	ths?		rth 2□Feta int at time of d		Ectopic pregnanc Other (specify)	У			lonth	Day Year
the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unknov								
that ed by deta		Part II. Other significant	t conditions cont	ributing to dea	ath but not resi	ılting in the ur	nderlying cause giv	ren in Part I.	23e. Did to	obacco use co	ntribute to t	he cause of death?
sign d be	d by	Luca	colo	Don	ia				10,	res 2□ No	3 ☐ Prol	pably 4 ⊠Unknown
requipeen	etec		7									
e lav	Ig .				·				24a. Was	osy	prior to co	ppsy findings available mpletion of cause of
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death,  Jo the Funeral Director: After this certificate has been signed by the attending phy  Sompletely filled in by the funeral director, page 2 should be detached for use as the	Completed								perro 1□ Yes	rmed? 2 <b>X</b> No	death? 1 ☐ Yes	2 □ No
Iclan Sertifi ector	Be	25. Was case referred to examiner?		spital:			04		ath (Check only o	ne)		
this a	2	1 Yes 2 No	110	1 1/2 in		ER/Outpatien		4 LI Nursing F	fome 5 ☐ Resid			(y)
ing F	ü	27. Manner of Death 1 Natural 5 [	Pending	28a. Date of (Month)	n, Day Year)	28b. Time of Injury	Wo		28d. Describe I	now injury occu	ırred	
tend eath tor:/	cati	2 Accident 3 Suicide 6	investigation Could not be					Yes 2 □ No				
ter d ter d lirec n by	Certification:	4 ☐ Homicide	determined		g, etc. <i>(Specif</i>		eet, factory, office		28f. Location (8 City or Tov		ber or Rur	al Route Number,
Ital or sal												
Hosp 4 hou Fune ely fi	ical	(Check only 2	Certifying Physi Medical Examine	er: On the ba	sis of examina	wledge, deat! tion and/or in:	n occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and r date and place	nanner as s e, and due t	stated. o the cause(s)
the hin 2 the mplet	Medical	one)		and mann	er stated.							
P N P N	-	29b. Signature and title	or cerumer	_			29c. Licens		_	29d. Date sign	ea (Month,	Day, Year)
18×160		1		/>2	2	0	HO	10-17	10	1/5/	0	<i>f</i> -
, Dd		_	person who or				•			, ,		
		Simone Eng	los E, Carr	11 5+	Salzi		1 3.124	4				
			المالي المالية				19 9180	1				
Sta Registi		31. Date filed (Month, Da	ay, Year) R 0 5 20	32. Re	gistrar's Signa		ld, onso	1	-			

1	_	For State
В	_	Registrar

ICITE	1	11	Dist.	111	- 4	11	Ė,
eg. No.	6	0			1		les

			1 - For State Registrar		Cei	tificate of	Death	Re	eg. No.	00946
	Physici		Decedent's Name (First, Middle, Last, Charle		BLER. Jr.			2. Date of Death Month	Day Year	3. Time of Death
100	/Medic		4a. Facility Name (If not institution, give		, , , ,		r Location of Death	march	4c. County of Death	16.50-
	LAGIIII		Washington County			Hagers	town		Washingt	on
	Funeral Director		Social Security Number 6. Sec.		yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, April 7	Year) 9. Birth	place (State or Foreign intry) : Virginia
- 0	pu ,		Usual Residence of Decedent	Tabe	O't. T					
	arylaı show dat	-	10a. State 10b. County  Maryland Washingto		City, Town or Lo					10d. Inside City Limits 1X Yes 2 No
	he M. 8a-f	ecto		711	lagerstow					
	ath with t 23a or 2 ust be n	Funeral Director	10e. Street and Number 1041 Benjamin Plac	e		10f. Zip Code 2	1742	10	U.S.A.	intry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If them 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fune	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 🖾 Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:	L942- I	Was Decedent of H If Yes, specify Cub I ☐ Yes 2KI No	dispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify:	
215-0036	nin 72 ho  in "natur Medical I	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done OO NOT use retired	oation during most of wor d)	king	16b. Kind of Business/li	ndustry
2121	d with giene er tha the I	E O	12	0	car	salesman			auto sal	es
P	al Hy l othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	flaiden Surname)	
<u>la</u>	wuld b Ment arked aric e	To	Charles A	mos Kibler,	Sr.			Sophia	Derr	
Maryland	12 should be filed w h and Mental Hygie 7 Is marked other ti raumatic event, th		19a. Informant's Name/Relationship (Ty D. Jacqueline Wals	*	I	-			City or Town, State, Zi	
	1 and 2 Health em 27 I		20a. Method of Disposition		Ob. Place of Dispo		SOII BIVE		20c. Location - City or T	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		1 ■Burial 2 □ Cremation 3 □ F	emoval from State	cemetery, crer	natory or other plac	ce) Mar	ch 11.	,	
Ħ	permit. Pag Department Important: I any Injury o	13	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens			en Cemete  . Name and Addre			Hagerstown,	
Ba	permit. Departn Imports any Inju		21. Signature of Fulleral Service Licens	<i>O</i> :					uneral Homerstown Mar	e ryland 21740
- No contract	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any feathing to limited date cause. Enter Underlying Cause (Disease or injury)	Due to (or se a cor	refulfic nsequence of):	^	mg, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death I Welk
68760,	The law requires that the death certificate be executed te has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Medical Examiner	resulting in death) Last	Due to (or as a cor		& 8TMAP	E			YCAM.
P.O. Box	the death cer by the attendin ached for use	Physician/W	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pr 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of delive Month	very Day Year
	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions col	ntributing to death but not	t resulting in the u	nderlying cause gív	ven in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to es 2 □ No 3 □ Pro	1
Division or Vital Records,		Completed						24a. Was ar autops perform 1∐ Yes 2	y prior to c	opsy findings available ompletion of cause of
Vit	<b>slcian:</b> Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital: 🛰		Oth		th (Check only one	9)	
0	<u>\$</u> .g . <del>\$</del>	-To	1 Yes 2 No	lospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien		4 Li Nursing H		nce 6 Other (Spec	ify)
rision	vttending death. ctor: After y the fune	Certification:	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Yea	Ar) Injury At home, farm, str	M 1□	yat k? Yes 2 □ No	28f. Location (Str	reet and Number or Ru	ral Route Number,
Οİ	spltal or A ours after leral Dire filled in by		4TIOTHIGIAE	building, etc. (Sp.		n occurred at the ti	me date and place	City or Town	, State)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2   Medical Exami	ner: On the basis of examend manner stated.	mination and/or in	vestigation, in my o	opinion, death occu	arred at the time, da	ate and place, and due	to the cause(s)
	wit To	-	29b. Signature and title of certifier	/mn.		04	6561	29	O 3 0 8	2008
00	H 5+1		30. Name and address of person who co			Print) ETMA RE	omo lto	1668570 WM	1 mn 21	740.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MAR 1 0 2008

College (1-4or 5+)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M,D

Hiis

32. Registrar's Signature

RIGILE

MAR 1 0 2008

Ç.

31. Date filed (Month, Day, Year)

Funeral þ Completed Be

၉

Examiner

Physician/Medical

þ

Completed

Be P

Certification:

Medical

State

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 Widowed 4 ☐ Divorced

items 23a Pages 1 and 2 should be filed within 72 hours after ō "natural", Department of H Important: If ite any injury or of once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice

Division or Vital Records, P.O. Box 68760

Elementary/Secondary (0-12)	College (1-4or 5+)	Ret. Sear	geant 1st Cla	SS	U. S. A	Army
17. Father's Name (First, Middle, La	est)			ne (First, Middle, M	faiden Surname)	
Unknown			Alleda	Narcissu	ıs	
19a. Informant's Name/Relationship Alleda Petto	(Type. Print)	7910 Ye.	ress (Street and Number or Ru Llow Springs R	iral Route Number, d., Frede	City or Town, State, 2 erick, MD	Zip Code) 21702
20a. Method of Disposition		Place of Disposition (	Name of or other place)	Date 2	20c. Location - City or	Town, State
1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other ( <i>Spe</i>	I I I Bemoval from State		n & Crem 03/1	4/2008	Philadelpl	nia, PA
21. Signature of Funeral Service Lic	censee					uneral Home
/- 3,0	XXX	305 1	N. Potomac Str	eet, Hage	erstown, M	D 21740
23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the death			or respiratory arre	st,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	_a. Inferete	2 Smin	il bovel			
resulting in death)	Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t	uence of):	icular Disec	. e		=21 hours
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence		3(76)			
If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	) _c					
resulting in death) Last	Due to (or as a conseq	uence of):				
	d					
IF FEMALE:						<u> </u>
23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	23c. If yes, outcome pf pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	il death 3 □Ectop	ic pregnancy (specify)		23d. Date of de Month	livery Day Year
Part II. Other significant condition	s contributing to death but not resu	ulting in the underlyin	ng cause given in Part I	23e. Did tob	acco use contribute to	the cause of death?
						robably 4 Unknown
Parch Fall	-e			24a. Was an	24b. Were a	utopsy findings available completion of cause of
				autopsy perform 1□ Yes 2	y pnor to ned? death? ?∑√No 1 ☐ Yes	
25. Was case referred to medical			26. Place of Dea	ath (Check only one		
examiner? 1 ∐ Yes 2 <b>∑</b> No	Hospital: 1 npatient 2	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 ☐ Reside	nce 6 Other (Spe	ecify)
27. Manner of Death  ↑ Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho		
3 Suicide 6 Could not 4 Homicide determine	t be 290 Bloom of injury . At he	ome, farm, street, fac (y)		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
29a. Certifier  (Check only one)  Certifying  2 Medical Ex	Physician: To the best of my kno kaminer: On the basis of examina and manner stated.	wledge, death occur ation and/or investiga	rred at the time, date and place ation, in my opinion, death occu	e, and due to the ca urred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
29b. Signature and title of certifier			29c. License number	29	9d. Date signed (Mon	th, Day, Year)
VIPIR.	کس		1)38764		3/8/0	8

1 ☐ Yes 2X No

16a. Decedent's Usual Occupation

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

Reg. No.

3. Time of Death

0530 AM

LΑ

1 X Yes 2 □ No

10d. Inside City Limits

Birthplace (State or Foreign Country)

2008

Washington

14. Race - American Indian,

White

Hogerston MD 21742

Black, White, etc.

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

US

2. Date of Death

8. Date of Birth (Month, Day, Year)

01/23/1920

Month

March

Registrar

16H-14+1

Campi Rd Sita 127

Phys /Me Exan

Funer Directo

and -transit

Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial-
	7
_	- MY

	For State Registrar			epartment of Certificate of	Death		Reg. No.	2008	0892
n al	1. Decedent's Name (First, Middle, Last  DAVID ALLEN LAMP)	,				2. Date of Dea Month MARCH	Day	Year 2008	3. Time of Death 12:05P
٩	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town	or Location of Deat	h	4c. 0	County of Death	
	6125 TOLCHESTER		(l	ROCK hdav) If Under 1 Yea	-	10 Bat (18:0		KENT	
	5. Social Security Number 506-58-0418 Usual Residence of Decedent	X M 2□F	(In yrs. last birtl	/rs. Months Day		8. Date of Birth (Month, Day 2/9/194	, Year)	9. Birth	place (State or Fore ntry) NE
	10a. State 10b. County MD KENT		10c. Cify, Town	or Location					10d. Inside City Limi
			- KOCF	-					
	10e. Street and Number 6125 TOLCHESTER	RD.		10f. Zip Code 21661			10g. Citiz	en of What Coul	ntry?
Ì	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	1-	4. Race - Americ	
١	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Y Yes 2 □ No If Yes, Give Year or Dates:	N/A	1 ☐ Yes 2 ☐ XV		to Alcan, etc.)		Black, White, Specify: WH	etc. ITE
	15. Decedent's Ec	ducation	16a.	 Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	upation e during most of wo	rking	16b. Kin	d of Business/In	dustry
	Elementary/Secondary (0-12)	College (1-4or 5+	)		red)		_		
Ì	17 Eather's Name (First Middle Last)	<u> </u>	SAI	ÆS	19 Matharia Nor	ne (First, Middle,		ENTAL	
	17. Father's Name (First, Middle, Last)	,				, ,		ourname)	
	GEORGE R. LAMPE	Time Drint)	101	Atallian Address (C)	_L	E. FRISBI		T C: :	0-4-1
	19a. Informant's Name/Relationship (	iype. rillil)		Mailing Address (Stre					o Coae)
İ	TOM LAMPE/SON  20a. Method of Disposition		20b. Place of	1 IVY RIDO Disposition (Name of		DATE Date		ation - City or To	own, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	cemetery	, crematory or other p	ION 3/6/	2008		ENSVILL	
	21. Signature of Funeral Service Licer	allel	1,)		ress of Facility HELFENBEI RDCHES				HOME
ŀ	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plication, that caused t	he death. Do no					21620	Approximate
	Immediate Cause (Final disease or condition resulting in death)			KTHEROSCE				W DISE	Interval Between Onset and Death
ı		Due to (or as a	consequence of	f):					
ŀ	Sequentially list conditions,	b. Due to (or as a	consequence o	D.					
l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	` = "	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•					
l	that initiated events resulting in death) Last	Due to (or as a	consequence o	f):				-	
l		~d							
1									
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	f pregnancy	3 □Ectopic pregnar			23	3d. Date of deliv	ery
1	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at t		5 ☐ Other (specify)				Month	Day Year
	9 Unknown	9∐Unknown							
	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying cause o	iven in Part I.	23e. Did to	bacco us	e contribute to t	he cause of death?
						1 🗆 Y	′es 2□	] No 3 ☐ Prol	bably 4 Onkno
						24a. Was a		24b. Were auto	ppsy findings availa
						perfo	med? 2 <b>X</b> No	death?	2 No
	25. Was case referred to medical				26. Place of Dea	ath (Check only o	,		
	examiner? 1 XYes 2 □ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outp	patient 3 DOA	ther: 4 \sum Nursing F	lome 5 Resid	lence 6	Other (Specia	fy)
	27. Manner of Death	28a. Date of Injury (Month, Day		me of 28c. Injury	ury at	28d. Describe h	ow injury	occurred	
	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		7.007		☐Yes 2☐No				
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.		28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one)  1 ☐ Certifying Ph 2 ₹ Medical Exam	nysician: To the best of niner: On the basis of and manner state	examination and	death occurred at the for investigation, in m	time, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) a	and manner as s place, and due t	stated. o the cause(s)
	29b. Signature and title of certifier			15°4/ 29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)
	Jonn &	Lance	POTON	itt DA	157509	'	7	, ,	ES
L	20. Name and address of	an malake days			•		-/	3/20	
-	30. Name and address of person who		atn (Item 23a) (T	ype, Print)					
-	1 217 65 1 A 1. 1/1 AM	23to	V LIA	DITATION	M 1 7 2	1 2 4			
	31. Date filed (Month, Day, Year)			DGNTUN,	MD 21	629			
-	31. Date filed (Month, Day, Year)  MAR 0 7	32. Registrar 2008		Books	MD 21	629			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08-01956 Jodi K. Lewis

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

odi K. Le	ewis		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrer  Certificate of Death Reg. No.	32
P ledical	hysicia Exami	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year March 9, 2008  3. Time of Death Month Day Year March 9, 2008	
Y			4a. Facility Name (if not institution, give street and number)  Peninsula Regional Medical Center  4b. City, Town, or Location of Death  Salisbury  4c. County of Death  Wicomico	
	uneral rector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign CountryDelaware) 1 Mnths Days Hours Min. 12/17/2007	
	any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin	mits
/land	28a-f show any d at once.	ē	Delaware Sussex Delmar 1 X Yes 2 10e. Street and Number 10g. Citizen of What Country?	No
ie Mary	or 28a fied at	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  604 E. Grove Street 19940 U.S.A.	
0036 Villings after death with the Maryland	or items 23a or 28a-f sho must be notified at once.	_ L	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
Us after o		2	3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 X No specify: Specify: White	
/// 136 hin 72 hou	Hygiene. I other than "natural" the Medical Examine	Completed	College (1-4 or 5+)   College (1-4 or 5+)   Unique most of working life. DO NOT use retired)   College (1-4 or 5+)   O   O   O   O   O   O   O   O   O	ш
21215-0036	F A F	Be Con	17. Father's Name (First, Middle, Last)  David Joseph Lewis  18. Mother's Name (First, Middle, Maiden Surname)  Michelle Leigh Cooper	
	and Mental I 7 is marked natic event,	P	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Michelle L. Cooper (Mother)  604 E. Grove Street - Delmar, Delaware 19940	
e, MD	nent of Health and Mental lant: If item 27 is marked or other traumatic event,	1	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
Baltimore, permit. Pages l at	nent of ant: If or other		Union-Greenbackville Cem. 03/15/08 Greenbackville, VA	
Balti permit.	Department Important: injury or of		21. Signatur of Funcial Service Latitusee 22. Name and Address of FacilityBradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817	
Phy	sician		Robert H. Bradsaw, Jr. 300 W. Main St Cristieid, MD 21817  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interpretation of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the pro	
	edical miner		Immediate Cause (Final disease or condition resulting in death)  a. Sudden Unex lained Death in Infancy (SUDI)  Due to (or as a consequence of):	
		<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	
cuted	ınd transit	EX	events resulting in death) Last Due to (or as a consequence or):  d	
O, be executed	ysician and burial - transit	edical	□ AMENDED 23a,27,28a-f per ME g878 5/1/08 amh	
Box 6876	attending ph or use as the	ΣΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	•
O. B.	signed by the			
ls, P.O.	en signe ald be de	ted b	1 Yes 2 No 3 Probably 4 ✔ Unknown	
of Vital Records,	cate has been s	Completed by	autopsy prior to completion of caus performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 N	e of
ital	his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 4 Inaction 2 PO Chartest and DOA Other. Nursing Home 5 Residence 6 Other.	
of V	After the	n: To	27. Manner of Death  28a. Date of Injury (Month. Day Year)  28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Division 1al or Attendir	death. sctor: yy the f	catio	Natural Accident  Solution  Solution  Accident  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution  Solution	City
Divi	ours after d teral Direct filled in by	Certification:	Suicide 6 X Could not be determined (Specify) Found in house or Town, State) 37455 Beam Port Rd., Greenbackville.VA	,,
the Hos	within 24 hc To the Fun completely	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
Ţ	To wit	Mec		
			Patri ann - Pollins O.C.M.E. March 10, 2008	
USC .	J		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	S ^s Regis	tate	AND IN THIS PROPERTY AND ADMINISTRA	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Keith Hallet Miller /Medical 27, 2008 4:03 p February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. 2, 1916 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 □ F 475-12-0489 91 South Dakota Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15100 Georgia Avenue 20853 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes XX No Specify: à 3 X Widowed 4 ☐ Divorced WWII Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Pilot Justice Department d 2 should be filed w h and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Miller Alice Bentley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is,
any Injury or other traus Paul V. Flaherty/Guardian 15100 Georgia Avenue, Rockville, MD 20853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State March Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Foherat Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spr Muan Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE LUU6 DISENSE **Physician** 5 y EARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit certificate be executed Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ned by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an certificate 2**∠**No Division or Vital 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph.
within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10 State

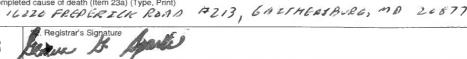
31. Date filed (Month, Day, Year)

FRANK J. MAYO, MA

29b. Signature and title of certifier

MAR 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

29c. License number

023630

29d. Date signed (Month, Day, Year) FEBRUARY 27, 2008

			For State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of		-	giene Reg. No. 201	08 08921
	Physici	an	1. Decedent's Name (First, Middle, Last)  Robert William McNamara		_		2. Date of Dea Month	2, 2008	3. Time of Death 1:55 p M
N.	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Deat		4c. County of D	
9	LXaiiii	GI	Randolph Hills Nursing Home	:	Wheat	on		Montgo	omery
	Funeral Director		296-01-8092 18 M 2□F 90	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug • 2	y, Year) 9. 1 1, 1917	Birthplace (State or Foreign Country) Ohio
	and www.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	tor	Maryland Montgo	merv	Silver	Spring			1 ☐ Yes 2 No
	th the or 28a e noti	irec	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	ath wi	ral	15004 Haslemere Court			906		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No l	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		pecify Yes or No to Rican, etc.)	. 14. Race - A Black, W Specify:	merican Indian, /hite, etc. White
15-00	רסט 72 ה "natura adical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wor	rking	16b. Kind of Busine	ss/Industry
12	withir iene. than	duc	Elementary/Secondary (0-12) College (1-4or 5	)+)	esman.	ω)		Newspaper	r
and 2	d be filed ental Hygi ced other c event, t	Be	17. Father's Name (First, Middle, Last) Thomas McNamara			18. Mother's Nar Ruby Se	, , ,	Maiden Surname)	
Maryland 21215-0036	nd 2 should the and Me 27 Is mark	ပ္	19a. Informant's Name/Relationship (Type. Print) Barbara M. Mallon/Daughte	I	ng Address (Street 205 Ros	and Number or Ro ecroft Ro	ural Route Number	er, City or Town, Stat kville, M	e, Zip Code) D 20853
Baltimore,	Pages 1 arent of Healt: If Item 3		20a. Method of Disposition  t☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crer Gate of H			Date arch 6,	20c. Location - City	
Baltir	permit. F Departme Importan any Injur		21. Signature of Funeral Service Licensee	22 F	2. Name and Addre	ess of Facility in:	s Funera	1 Home In	ring,Maryland c. ring, MD 2090]
	Physician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list Immediate Cause (Final						Approximate Interval Between Onset and Death
8760,	/Medical Examiner physician and the pririal-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events c.	a consequence of):  a consequence of):  a consequence of):					Years
P.O. Box 68	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	∃Ectopic pregnanc ∃Other <i>(specify)</i> _	у		23d. Date of Month	delivery Day Year
	quires that n signed k uld be dett	by	Part II. Other significant conditions contributing to death b Pleural Effusion, Hypertens	-		ren in Part I.			e to the cause of death?  Probably 4 Hunknown
Division or Vital Records,	The lavate has	Completed					24a. Was autor perfo 1∐ Yes	osy prior rmed? deat	e autopsy findings available to completion of cause of h? res 2  No
Κ	Physician: The this certificate all director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Outpatien	t 20 DOA Oth		ath (Check only o		2
on or	ding Phy h. After this funeral d	$\vdash$	27. Manner of Death  1 Matural 5 Pending (Month, Date of Including a Control of Death Investigation)	ry 28b. Time of	f 28c. Inju	41_ Nursing F		dence 6 Other (S	Specity)
Divisi	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	- C	ury - At home, farm, str c. <i>(Specify)</i>			28f. Location (5 City or Tox	Street and Number o vn, State)	r Rural Route Number,
	ne Hospita 124 hours ne Funera bletely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner street.	f examination and/or in	h occurred at the ti	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To ti To ti comp	Ň	29b. Signature and title of certifier	٠	29c. Licens			29d. Date signed (M	
	10		Musiadhat	-clen, H.	1)	7630		March	4, 2008
			30. Name and address of person who completed cause of d			#200 03	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ing MD 2	0902
	Sta	te	31. Date filed (Month, Day, Year) 32 Registr	01 Georgia ar's Signature		#209, S1	iver Spr	ING, MU Z	0304
	Registi		MAR 0 5 2008	. He dos	rate o				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 3 0801 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number **Funeral** Year) Months Days Hours 1 M 2□ F 213-16-Director 10 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1XYes 2 No **Funeral Directon** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Race - American Indian Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black. White, etc. 1 Yes 2 No Wyes, Give Year or Dates: Army 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) artment of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris injury or other traumatic ္ Jane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Morris Martena 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3/10 4 □ Donation 5 □ Other (Specify) permit.
Decartor
Importa
any inj Frabell a 22. Name and Address of Facility Birmie se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 5mith MO Approximate Interval Between Onset and Death 23a. Part1. Enter the di shock, or heart fail one cause on each line Immediate Cause (Final disease or condition resulting in death) ASCVD 120 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: if yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**X** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred in by the funeral 27. Manner of Death after death. I Director: After t Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 29a. Certifier t 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 108

State Registrar 31. Date filed (Month, Day, Year) 32 MAR 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

100 E Caroll St.

MO 21801

Salisbury

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1100 DONALD L. MELSON, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** cional Matical Shill Grant Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Stre Birthplace (State or Foreign Country) If Under 1 5, Social Security Number 4 6. Sex 1 M 2 □ F Days **Funeral** Months DELAWARE 65 MARCH 30, 1942 221-26-4656 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Directo SUSSEX BRIDGEVILLE DELAWARE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 19933 18066 BARNES ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 ģ 3 N Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than * Elementary/Secondary (0-12) College (1-4or 5+) STATE OF DELAWARE HEALTH INSPECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUTH M. McCAULEY DONALD L. MELSON, SR. ပ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18066 BARNES ROAD, BRIDGEVILLE, DE 19933 Department of Health a Important: If item 27 is any Injury or other trainonce. REBECCA L. MELSON/ DAUGHTER altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State BRIDGEVILLE, DELAWARE 03/06/2008 BRIDGEVILLE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) M00866 21. Signature ²²PARSELL FUNERAL ENTERPRISES, INC. 202 LAWS STREET, BRIDGEVILLE, DELAWARE 19933 Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e, or complications that cause List only one cause on each I 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician s the buria Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 TYes 2 \ W Inpatient 2 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Certification: After (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner extrated. 29a. Certifier Medical (Check only one)

Jen

State Registrar

8 100 32. Regiarrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title a certifier

Carroll

29c. License number

Street

020441

29d. Date signed (Month, Day, Year)

08

			State of Marylar		irtment of H <i>tificate of L</i>			ene2008	3 08930
1	Dhyaiais		Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic	al	Phyllis Elaine MEYER  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	March	4c. County of Dea	4:50 P.M.
	Examin	er	Washington County Hospital		Hagerst	own		Washingt	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 F 7. Age (In yrs. 1 M 2 1 1 F 8 6 6 6 Sex 1 M 2 1 1 M 2 1 1 F 8 6 6 6 6 Sex 1 M 2 1 1 M 2 1 1 M 2 1 1 M 2 1 1 M 2 1 1 M 2 1 M 2 M F 8 6 6 Sex 1 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M	last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 16	^{Yea} r) 9. Bi 1920 Ma	rthplace (State or Foreign country) ssachusetts
	D		Usual Residence of Decedent  10a, State 10b, County 10c, Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Maryk 1-f sho fied at	ţo	Maryland Montgomery Si	lver Sp	oring				1½∏Yes 2 ☐ No
	with the a or 28a t be noti	Direc	10e. Street and Number 3910 Ilford Road		10f. Zip Code 2090	6	10	og. Citizen of What C	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give	1	Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2⊠ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
200-012	nin 72 hours In "natural" Medical Exa	Be Completed b	3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work l)	ing	16b. Kind of Busines	s/Industry
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<u>מ</u>	d be fill ental H ked oth c even	To Be	17. Father's Name ( <i>First, Middle, Last</i> )  Myron Harlow				arion Tru		
ğ	2 shoul and Me Is mari	F	19a. Informant's Name/Relationship (Type. Print)	1	-			City or Town, State,	
ນ໌ ປັ	1 and 2 Health em 27 ther tra		David L. Meyer - son  20a. Method of Disposition 20b.		Bethlehem sition (Name of natory or other place			vn, Maryla	
	Pages nent of h int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren arklawn	matory or other place Memerial Memerial	Marc 20	$_{08}^{\mathrm{h}_{010}}$ , $_{\mathrm{R}}$	ockville,	Maryland
Dallillo	permit. Departin Importa any inju		21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility		Funeral Herstown, M	ome Maryland 21740
	Dhasisian	N (i	23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.		er the mode of dyin			est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a	quence of):	DIFFICE	CG CUL	1112		1
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	scuted nd transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		TUT INFO	FLION			1 week
9/00,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last  Die to (or as a conse		iondan +	o Alviz	Fract	/\ull	1 ~ 1
O. BOX 0	death certifi e attending id for use as	Physician/Me	F FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3□	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	lelivery Day Year
. Y.	requires that the een signed by th rould be detache	þ	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tol		to the cause of death?  Probably 4 Unknown
ecords,	law requias been se should	Completed					24a. Was a	n 24b. Were	autopsy findings available
r	The ate he	Somp					autops perfori 1∐ Yes		
VII	nystcian: Th	Be	25. Was case referred to medical examiner?  1 ★ Yes 2 No Hospital: 1 ★ Inpatient 2	☐ER/Outpatier	nt 3 DOA Oth	er.	th Check onl on		and A
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UNISION	Attending Physician: r death. ector: After this certific. by the funeral director,	icatio	2 Accident investigation 2/13/08	nome farm str	M 1 🗆	Yes 2 No	U	LEVEL Fa	Rural Route Number,
2	pital or ours afte eral Dir filled in	al Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of injury - At building, etc. (Spec Loyalton AS)  29a. Certifier  1 ☑ Certifying Physician: To the best of my kn	St. Livi	ng h occurred at the ti	me, date and place	2009 p	n, Sta <i>te)</i> OSC bcmk W ause(s) and manner	lay flagastown as stated.
	To the Hos within 24 hc To the Fun completely	edical	(Check only 2 Medical Examiner: On the basis of examiner) and manner stated	ation and/or in					
	With To	Σ	29b. Signature and title of certifier  (Cectury MI)	SHI!	mt, 29c, Licens	46561	2	9d. Date signed (Mc	09, 2008
	HJ		30. Name and address of person who completed cause of death lite	/		fre. en ro	un M	2 0	740.
S P	Sta	ate	31. Date filed (Month, Day, Year) 32. Relistrar's Sign	101 111 1	Rock :	THOUND	WIN IV	0-1	
	Registr	rar	MAD 1 A 2008	AT A	A Sec. Late				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 1, Day 2008 Year **Physician** Yu1y Neyman 11:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3553 Bantry Way 01ney Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8, Date of Birth
Months Days Hours Min. (Month, 10g) 9. Birthplace (State or Foreign **Funeral** Months 6/M97-191 9ar) Courraine 1 X M 2 □ F Director 218-25-0854 88 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

sther than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD Montgomery 01ney 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3553 Bantry Way 20832 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 Is marked other that any Injury or other traumatic event, the ionce. College Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Yuzef Nevman Raisa Spegel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Neyman - Son 1906 Dundee Road Rockville MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (*Specify*) 3/4/08 Rockville, MD 21. Signature of Funeral Service Line 22. Name and Address of Facility Panzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 815 /Medical Due to o as consequence of): Examiner Sequentially list conditions, in any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and is the buriaf-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Vear Day 4☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 22 No page 2 certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Yes 2 No Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 9 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 🗌 Natural -3=15 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. mar / 2008 1 🗌 Yes 2 Accident 3 Suicide 4 ☐ Homicide 6 ☐ Could not be Local n (Street and Number City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Bant 3 20833 JAG. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. ature and title of certife 29d. Date signed (Month, Day, Year) 29c. License number 2 MO DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 cal BRECKER mo omt . Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 5 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Brooks Oakley Barbara 2008 February /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner HOSMICO If Under 24 Hrs. Birthplace (State or Foreign Country) Year Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F 86 216-40-3717 Director 3/30/1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Salisbury Wicomico Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21801 611 Tressler Drive death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Specify: þ white 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) anould be filt.
Ith and Mental Hv. 17. Father's Name (First, Middle, Last) Be Flora Buracker Henry alvin Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 Is any injury or any 4140 Heather Way, Salisbury, MD 21804 Willard Oakley, Jr/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/4/08 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic 22HoTToway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (ESP Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 No 2 No 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After t (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: 24 hours after death e Funeral Director: To the within 2

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DHMH 17 Rev 1/2001

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

MAR 05

2008

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Easkin Styne Dr Salis kury MD2180

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:00 A M Mabel Culbertson Olwine March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home tavre de Har Mursing Grace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 ☐ M 2 🛣 F Hours Director 192–16–0326 88 11/19/1919 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exa<u>miner must be notified at</u> 1

Yes 2

No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 Paul Drive 21001 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 If Yes, Give Year or Dates: **≩⊠**No ve 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3℃Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the s Elementary/Secondary (0-12) College (1-4or 5+) 11 Clerk Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Culbertson Mabel Gaskill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra C. Allen (Daughter) 704 Paul Dr. Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/15/08 R. A. Ferris & Co West Chester, PA 21. Signature of Iperal 9 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between EKEPROVASCULAR Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine and the burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) U[W]Me, MMDe! Division or Vital Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1□ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient ဥ 1 🔲 Inpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t Certification: To the Hospital or Attending 5 ☐ Pending investigation Natural 1 Yes 2 No death. 2 Accident **Director:** 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after 4 Homicide To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type,

State Registrar 50014

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2008 Geraldyne Aull Pierce March 14, 7:45 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1006 Race Street Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗹 F Director 442.40.3689 68 1939 Oklahoma Dec. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 1 Yes 2 No Dorchester Directo Maryland Cambridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 Race Street 21613 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salvation Army Officer Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Richard Aull Nellie Kent 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau Major Edward L. Pierce (Ret) <u>1006 Race Street, Cambridge,</u> MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) DorchesterMemorialPark 3.18.2008 Cambridge, Maryland 21. Signature of Funeral Service Licensee Curran-Bronwell Funeral Home, P.A. 308 High St., Cambridge, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) Encephalopai Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as attending IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Day ed by the a 5 Other (specify) P.0. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 🗌 Yes 3 Probably 4 ☐Unknown 2_\No Completed 24a. Was an autopsy performed? 1□ Yes 2 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes ٩ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatore and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type Frint)

32. Registrar's Signature

MAR 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 640 M 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner nes 100sona MUSY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F 83 169-30-0044 Director PA 1/18/1925 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show notified at 1 ☐Yes 2 No Director DE SUSSEX **LEWES** 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hems 23a or 2 Iner must be n Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 33349 WOODLAWN CIRCLE 19958 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates WHITE "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARTIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked c THOMAS E. WALTON GEORGIA BONNELL ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 JAMES H. PARCHER/HUSBAND 33349 WOODLAWN CIRCLE LEWES, DE 19958 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WEST LAUREL HILL 3/14/08 BALA CYNWYD, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unkno signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 Probably Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 TYes Hospital or Attending Physician: funeral director Be 25. Was case referred examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA Inpatient eath 27. Manne Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury atural 1 🗌 Yes 2 □ No 2 Accident after death | Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

ms

h (Item 23a) (Type, Print)

32. Regist

r's Signa

30. Name and address of person who completed cause of dea

31. Date filed (Month, Day, Year)

8-01823 - Charles E. Phillips	Please Type or Print in Black Indelible Ink. Ensure All Copies	
nanes E. Primps	State of Maryland / Department of Health and Mental Hyg  1-For State	2000 0003
	Registrar Oct Unicate Of Death	Reg. No. 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
Physician/ Vledical Examine		Month Day Year 1104 hrs
The same	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
	3004 Wylie Avenue Baltimore	Baltimore City
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	Months Days Hours Min.	1-20-1942 Foreign Country) MD
	Usual Residence of Decedent	20 1712
any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
<u> </u>	MD Baltimore City Baltimore	1 Yes 2 No
Maryland 28a-f show 1 at once. ector	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
the Maryland a or 28a-f sh tifted at once	3004 Wylie Ave 21215	USA
with the Maryland as 23a or 28a-f sho be notified at once, real Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	ify Yes or No- 14. Race - American Indian, Black,
r death with or items 23 must be no Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rie	can, etc.) White, etc.
Mer of		Specify: Black
hours aft  f.natural"  Examine	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of wor during most of working life. DO NOT use retired	
5 72 h ral Eal Eal Eal Eal Eal Eal Eal Eal Eal E	Elementary/Secondary (0-12) College (1-4 or 5+)	
5-0036 led within 72 hour. lygiene. other than "natu the Medical Exan Completed	ZYr. Welder	Bethlehem Steel
5-0 iled v Hygiv		irst, Middle, Maiden Surname)
121: d be fill lental B arked arked;		Wickes
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once To other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, P nt.) (Daughter) 19b. Mailing Address (Street and Number or Rur  Andrea From Phillips P.O. Box 1494 B	ladenboro, NC 28320
, MD 2 and 2 shoul lealth and N tem 27 is n traumatic		Date 20c. Location - City or Town, State
Ore of He If it	1 Burial 2 Cremation 3 Removal from State crematory or other place)	
im Pag ment tant:		8-08 Rock Hall, MD
Baltimore, ME permit Pages I and 2 s Department of Health at Important: If item 27 injury or other traum	21. Signalure of Funeral Service Licensee 22. Name and Address of Facility	an man a Silinata a da
	23 Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or n	H - 717 w. Division 54 espiratory arrest, shock, or heart Approximate Interval
Physician /Medical	failure. List only one cause on each line.	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):	- Double
	be to (e. to to to to to to to to to to to to to	
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted nisit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c	
EX sit	events resulting in death) Last Due to (or as a consequence of):	
executed ian and ial - transit	d.  UNPENDED AMENDED	
	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
). Box 68760, the death certificate be to the attending physicic thed for use as the buris. Physician/Medi	23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy	
x 6 th cer trendi	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
BOS e death the att	1 Yes 2 No 9 Unknown 9 Unknown	
P.O. E s that the d gned by the d detached by D Phy		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
S, P	Renal Disease	
Records, I The law requires fricate has been sig	Chronic Alcoholism	24a. Was an autopsy findings available prior to completion of cause of
ecc he lav ate ha		performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical 26. Place of Death (Check of	lly one)
F Vital Physician To Be	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing	Home 5 Residence 6 ✔ Other: Scene
Division of Vital Records, P.O. tal or attending Physician: The law requires that the rather death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P		8d. Describe how injury occurred
ion tendii eath. the fu	1 Natural 5 Pending 1 Yes 2 No	
ivisi or Att after de Direct Lin by	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	8f. Location (Street and Number or Rural Route Number, City or Town, State)
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	4 Homicide determined (Specify)	
		ue to the cause(s) and manner as stated.
To the Howithin 24 P. To the Funcompletely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	
Z		29d. Date signed (Month, Day, Year)
5	M $M$ $M$ $M$ $M$ $M$ $M$ $M$ $M$ $M$	March 5, 2008
	30. Name and address of person who completed cause of death (Item 23a)	
~5	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State		
Registra	MICH A A SOUTH OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF	OCME

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 40 p M Physician CREOLA VIRGINIA ROBINSON MARCH 2008 /Medical 4a. Facility Name (If not inspitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 21/2 F 218-22-0726 81 Director MARYLAND 1926 MARCH 23, Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d, Inside City Limits itams 23a or 28e-f ahov other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MARYLAND HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 CORNS DRIVE 21015 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 M2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Marned ŏ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3€ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VALLEE RICE HELEN HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 GLORIA J. PERRY / NIECE 400 DEVONSHIRE COURT, ABERDEEN, MARYLAND 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of H
Important: if ite
any injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CLARKS UNITED METH CEM 3/8/08 BEL AIR, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) LISA SCOTT FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee set - Coloma 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 months
1 Yes 2 100
9 Unknown Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 201NO 1 ☐ Yes 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certification: To 1 🗆 Yes 2 No 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 12 Natural 5 Pending Vitin 24 hours after death.

To the Funeral Director: Af investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 3 30. Name and address of person who completed cause death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once.

Director

Funeral

Completed by

Be

with the Maryland

certificate ha frector, page 2 : After this certification funeral director, n 24 hours and the Funeral Director: Af

by Completed Be

Examine

Physician/Medical

Certification: To

Medical

State Registrar

Shahid Mahmood MD 31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

within 2.

MAR 1 0 DHMH 17 Rev 1/2001

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistrarAMEND#23a(b)perMD 3/5/08,BMW,MoOo Certificate of Death 2. Date of Death Year **Physician** Month Day Jeanne Slovon February 20, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital 01ney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Director 579-42-6090 75 21, 1932 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f shov ral", or items 23a or 28a-f sh Examiner must be notified 1X Yes 2 □ No Directo MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3204 Gleneagles Drive 20906 U.S.A. 14. Race - American Indian, by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If Item 27 is marked other this any injury or other traumatic event, the once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Gordon 2 Katie Tubour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven M. Slovon - Son 23605 White Peach Ct. Gaithersburg, MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gdns. 2/22/2008 Olney, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, 1170 Rockville Pike Rockville, MD 20 Donald ( tottlemyer 23a. Part1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIOPULMONARY ITOURS /Medical Due to (or as a consequence of): Examiner Ischemic Brain Injury Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 □ Pregnant at time of death 9 □ Unknown 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | detriknown CARDIO MYOPATIT 24b. Were autopsy findings available prior to completion of eause of death?
1 ☐ Yes 2 ☐ No 24a, Was an ate has page 2 s autopsy performed? certificate 1∐ Yes 2 12 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P After this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a e Funeraí I 11. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H00(05661 2/30/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip Drave Oliney, MO 18101 Stein, DO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 5

Buy 2 3 A Ok Per C. Nermannek (MES of the

Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Day **Physician** MARCH 2008 6:29PM M MYRTLE W. STECK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT WILLIAM HILL MANOR EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days 1 M 2 K F 94 Yrs. APR 13, 1913 CALIFORNIA 565-05-6656 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. Counfy 1 XYes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DUTCHMANS LANE 21601 USA Funeral 501 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【No Specify: <u>م</u> Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY GLASS MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE WEAMER AGNES CAMPBELL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET S. JARBOE/DAUGHTER PO BOX 58, SHERWOOD, MD 21665 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 3/3/2008 STEVENSVILLE, MD 21. Signature of Euneral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 27. I oseph Strousis 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JACUMONIA day Due to (or as a consequence of) Due to (or as a consequence of)

Month

Day

Vear

**Physician** /Medical Examiner

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

with the Maryland

Examiner Physician/Medical þ Completed Be

Certification: To

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The law requires that the death certificate be executed or Attending nours after death.

neral Director: A within 24 hours a To the Funeral C Hospital

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manuer stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

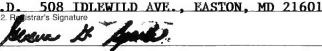
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANCHEZ M.D. ROBERT B.

31. Date filed (Month, Day, Year)

2008 MAR 04



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death FH. TCHD. 03/05/08 pha 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year Physician Wesley 29 2008 Hammond /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 0+ Baltimore Under 1 Year | If Under 24 Hrs. University

5. Social Security Number Mardand Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1**M** 2□F Days Hours Min. Maryland Director 216-18-0646 07 - 25 - 192483 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County show r 28a-f show notified at 1 Yes 2 No Director Md. Kent Worton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be i 24861 Lambs Meadow Road 21678 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Black Specify: Specify Completed by 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mastens Lumber river 9 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Raymond Seth Nora Hammond ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) Daug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 129, Worton, Maryland 21678 Atia Brechelle Johnson/ Baltimore, 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Church Cemetery 03-08-08 Worton, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityBennie Smith Funeral Home 1. Signature of Fundral Service Licensee Road 298, Chestertown, Md. 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician et leural /Medical Due to (or as a consequence of) Examiner eumoni. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed sician and burial-trans Advance cance Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.O. 9□Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

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5+VA

State Registrar

MAR 0 5 2008

31. Date filed (Month, Day, Year)



of death (Item 23a) (Type, Print)

Greene St.

Bultimore,

Funeral Director

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Se				o a ii c								P.A. F.H.
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Sta	te	31. Date filed (Month, Day,	Year)	32. F	Registrar's Sig		ali							
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		3	Decedent's Name (First, Middle, Last)						T	2. Date of Dea	ath	2000	3. Time of Death
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والماء الماء	Funeral Director		213-44-1740		2	last birthday) Yrs.	Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day June 22	v, Year) 2, 19	9. Birthol Count Mary	ace (State or Foreign Tland
	and t		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10	Od. Inside City Limits
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36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	10		1⊡Yes 2 <b>∏</b> No	Specify:					ite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed k	15. Decedent's Educ	cation		16a. Deced	lent's Usual Occu	pation			16b. Ki	ind of Business/Ind	ustry
215	hin 72 e. an "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	+)	(Give life, L	kind of work done OO NOT use retire	during most d)	of working	ig .			
21	d with	Som	10	- College (1 lot c		Equip	oment O	perat	or		Cc	nstruct	ion
pu	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)							(First, Middle,		,	
yla	ould I Men narke	To	William Cullu									se Teal	
Maryland	d 2 st th and <b>7 is n</b> traun		19a. Informant's Name/Relationship (Type Charlotte A. Si	,		1					-	or Town, State, Zip e Hall, M	1
Ď,	Heal Heal tem 2		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of	1	D.	ate		ocation - City or To	
<u>o</u> E	ages ent of nt: If ii		1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			natory or other pla Cemeter		arch 2008	17,	Par	rkton, N	Maryland
altimore,	mit. F partme sortar injur		21. Signature of Funeral Service License			22		- : -		. Hart	ensi	tein Mort	uary, Inc.
m	any any		Muchael V.	Meun	me	_ 2	24 Secon	d St.	, Ne	w Free	edon	n,PA 173	349
	-2		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused ne cause on each lir	the dea	th. Do not ent	er the mode of dyi	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				LL CAN					SINUS	Onset and Death  4EAPS
	/Medical Examiner		resulting in death)	Due to (or as						PERMIT			
	#8	ī	Sequentially list conditions, b	Dus to (or as	s eonsor	испес об							
	rted I Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0. 00		, 4000 0.,							
Ć.	execting and ital-tra	Examiner	resulting in death) Last	Due to (or as	a consec	quence of):							
68760,	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	edical	d	J									
	ertifica ing ph as th		IF FEMALE:										
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Feta	al death 3□	Ectopic pregnanc	:у				23d. Date of delive Month	ry Day Year
P.O.	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of o	death 5∟	Other (specify)_						24,
	The law requires that the death cert ite has been signed by the attending bage 2 should be detached for use a		Part II. Other significant conditions con	itributing to death bi	ıt not res	sulting in the ur	nderlying cause gi	ven in Part I.		23e. Did to	obacco u	use contribute to th	e cause of death?
rds	quires n sign ald be	d by								1 🗀 Y	res 2	Mari No 3 ☐ Proba	ably 4 ∐Unknown
000	aw requir s been si	Completed								24a. Was	an	24b. Were autop	osy findings available
æ	The lay	ош									osy rmed? 2∡No	death?	npletion of cause of 2 No
ţ	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o		7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20110
<u>&gt;</u>	hysic his ce	To E	1 ☐ Yes 2 No	lospital: 1   Inpatie	nt 2 [	ER/Outpatien	1 3 DOA		rsing Hon	ne 5 ☐ Resid	dence	6 Dther (Specify	HOSPICE
Division or Vital Records,	After t	on:	27. Manner of Death  1, Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y ' Year)	28b. Time of Injury	Wo			8d. Describe h	now injur	ry occurred	
isio	death death stor: , the f	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of inju	ını - At h	ome farm str		Yes 2 N		of Location /9	Stroot on	nd Number or Rurai	I Pauta Number
<u>≥</u>	after Direction by	Certification:	4 ☐ Homicide determined	building, etc			ooi, ractory, omoc		-	City or Tou			noute Namber,
	Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the		29a. Certifier 19 Certifying Phys	ician: To the best	of my kno	owledge, death	occurred at the t	ime, date and	d place, a	and due to the	cause(s)	and manner as st	ated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	(Check only 2 Medical Examir	ner: On the basis of and manner sta	examina ted.	ation and/or in	vestigation, in my	opinion, deat	th occurre	ed at the time,	date and	d place, and due to	the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	~			29c. Licens					te signed (Month, L	
)			1000	1		^		4395			MA	RCH 121.	2008
			30. Name and address of person who con					T 011.	72 7	na n	رس <del>و</del> و و	MADE MAN	2,204
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Sign	ature ature	HILLES S	y sul	164	UT BA	1111	rune, me	21207

State Registrar



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Maryla		partment of F ertificate of a			giene 2008	08946
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ith Day Year	3. Time of Death
	Physicia /Medic		Gerald Hudson	Schaffer				March	12, 2008	10:41A M
4	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. County of Death	
			Harford Memorial		· · · · · · · · · · · · · · · · · · ·		e de Grac		Harford	
	Funeral Director		212-30-3875	7. Age (In yr	rs. last birthd Yrs	Months Davs	II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02/15/	y, Year) 9. Birthp Cour 1935 Mar	lace (State or Foreign http) YLAND
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or	Location			1	0d. Inside City Limits
	atter death with the Marylan or Iteme 23a or 28a-1 show miner must be nutified at	ļo	MD Harkore	,	Haut	e de Grace	1			1 ∑(Yes 2 ☐ No
	1 28a	Director	10e. Street and Number	i	Havn	10f. Zip Code			10g. Citizen of What Cour	ntry?
	A with		909 Eugene Drive	2		21078	Š		U.S.A.	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	3. Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	14. Race - Americ Black, White,	
9	be filed within 72 hours after death with the Maryland tal Hygjane. d other then "natural", or Iteme 23s or 28s-f show event, the Madical Examinar must be nutified at		1 Never Married 2 Married	1 ⊠Yes 2 □ No If Yes, Give		1 ☐ Yes 2月 No	Specify:	, ,	Sanaihu	
Marvland 21215-0036	72 hours aff "natural", or	d by	3 ■ Widowed 4 Divorced  15. Decedent's Ed	Year or Dates: 194		cedent's Usual Occup	pation		16b. Kind of Business/In	ite
<u> </u>	in 72	olete	(Specify only highest gra	de completed)	(G	ive kind of work done  o. DO NOT use retired	during most of world)	king	Tob. Kind of Daginosami	austry
212	iane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Mo	intenance			Civil Se	rvice
ğ	il Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
<u>a</u>	uld b Menta Menta rrked	ToE	Benjamin Schaffe	er			Gladys	Hudson		
a	2 should and Mer Is marks		19a. Informant's Name/Relationship (7	Type, Print)					r, City or Town, State, Zip	
	s 1 and 2 should be filed within the lith and Mental Hygiane. If the 27 is marked other then other treumatic event, the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market in the Market i		Kimberly Donovas	n (daughter)	141	8 Bauview sposition (Name of	Drave. H	oure de	Grace, Mary 20c. Location - City or To	Cond 21078
)4/A Baltimore.	ges 1 If of H or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domoval from State	cemetery,	crematory or other pla	ce)			
二二	it. Pertiment		4 Donation 5 Other (Specify		argore	22. Name and Addre			Aberdeen	
041 A Baltimo	permit. Peges 1 and 2 Deportment of Health a Important: If Item 27 is eny injury or other tre	1	TO LOW O	300 may		1.0.2 0 //	Ze	llman Fu	ineral Home,	P.A.
~	_	(	23a. Part1. Enter the disease, or complete shock, or heart failure. List only	plications that caused the de	eath. Do not	enter the mode of dyir	ng, such as cardiad	or respiratory ar	rest,	Approximate
	Physician		Infinediate Cause (Final	one cause on each line	- 10	. Inon	ari	Arrox	7	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of):	ulmon	ary 1	11123	-	
	Examiner		Consection to the Store	5	,		J			
$\infty$	<b>P</b> ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
2/5	cate be executed physician and the buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for so a cons	and and after					
20.09	be exician sourial	E	Todaking in doubly East	Due to (or as a cons	equence or).					
3/1/8	physi	dicai		d						
, 8	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-					23d. Date of deliv	ery
Box	death certifi e attending   ed for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	y 		Month	Day Year
Do		hysi	9 Unknown	9□ Unknown					<u>l</u>	
0	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	by P	Part II. Other significant conditions of	contributing to death but not	resulting in th	e underlying cause gr	ven in Part I.		obacco use contribute to t	/
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	The ate h	Con	J						rmed? death? 2☐160 1☐ Yes	2 □ No
Vital V	Physician: The lavithis cartilicate has	Be	25. Was case referred to medical examiner?	Hospital:		. 04	200	ath (Check only o		
	Physi this c	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpa 28b. Tim	ILIBRIL 3 DOA			dence 6 Other (Speci now injury occurred	fy)
haffe Division of	tending Physeath.	ton	1 ☑Natural 5 ☐ Pending	(Month, Day Year	) Inju	ry Wo	rk? Yes 2 □No	200. 2000.120		
Q isi	or Attend effer death Director: , in by the f	flca	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - A	t home, larm				Street and Number or Aur	al Route Number,
chaffe Division of	al or setter	Certification:	4 Homicide	building, etc. (Spe	ecity)			City or Tov	vn, State)	
Sign	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: Affer this cartificate he completely filled in by the funeral director, page		(Check only 2 Medical Exar	nysician: To the best of my miner: On the basis of exam						
P	thin 2 the 2 mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen:	se number		29d. Date signed (Month,	Day, Year)
			10000	ow, mo						67
	421		30. Name and address of person who	completed cause of death (	Item 23a) (Ty	(pe, Print)	140 11		March 12, le Grace	2008 MD 21078
			GAO, Winglin	501	J 4	mien A	ve Ho	avre	it yrace,	MD 4010
	Sta Regist		31. Date liled (Month, Day, Year)  MAR 1 9 200	Registrar's Si	grature	ork)				

		Please Type or Print				
		1 _ State	ryland / Department o <i>Certificate</i> (		2000	08947
	88	Registrar  1. Decedent's Name (First, Middle, Last)		2. Date	Reg. No.	3. Time of Death
. Physi /Med	cian dical	Gary Thomas Todd	Sr.	Mon	113 35 88	1444 M
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Tov	n, or Location of Death	4c. County of Dea	
Funera	al E	FEDIOSULA FEGIONAL MEDICAL   5. Social Security Number   6. Sex   7. Age (	(In yrs. last birthday) If Under 1 Y	ear If Under 24 Hrs. 8. Date	of Birth 9. Birth, Day, Year)	thplace (State or Foreign
Directo		217-26-8636 ^{1™ 2□ F} 89	Yrs. Months D.			ountry) aryland
and		Usual Residence of Decedent  10a. State 10b. County 1	10c. City, Town or Location			10d. Inside City Limits
Maryl Ff sho	ţċ	Maryland Wicomico	Salisbury			1 🔀 Yes 2 🗆 No
th the or 28a e noti	Director	10e. Street and Number	10f. Zip Co	de	10g. Citizen of What C	ountry?
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ter de	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ X € s □ No If Yes, Give	er in U.S. 13. Was Decedent If Yes, specify	of Hispanic Origin? (Specify Yes Cuban, Mexican, Puerto Rican, e	s or No- tc.) 14. Race - Ame Black, Whi	
5-0036 72 hours af natural", or dical Exami		3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	Army/ 1□ Yes 202 Corp	No Specify:	Specify:	white
Ind 21215-0036  be filed within 72 hours after death with the Maryland tital Hyglene.  cd other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notifited at	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual O	ocupation one during most of working etired)	16b. Kind of Business	/Industry
2121 ed within /giene. er than "	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		Sales Executive	Rubber Mi	llers
e filed al Hygi other vent, th	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, I		
aryland 2 should be filed ind Mental Hygi marked other umatic event, t	P	Dr. Homer Ulrich Todd		Alice Rukl		
Manual Ithan		19a. Informant's Name/Relationship (Type. Print)  Robin Todd English/daughter		reet and Number or Rural Route erside Dr., Sal		
Baltimore, IV  Dermit. Pages 1 and 2 Department of Health mportant: If item 27 i		20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other	of Date	20c. Location - City or	Town, State
Pages ment of ant: If its		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Salisbury Crem	atory 3/5/08	Salisbury,	
Baltimol permit. Pages Department of important: If it any Injury or or	ouice.	21 Signature of Funeral Service Licensee	22. Name and A HOLLOWA	ddress of Facility Y Funeral Home	Professional A	Association
WE KNOW	4-	23a. Part1. Enter the disease, or complications that caused th	ne death. Do not enter the mode of	Hill Rd., Sal	1	Approximate
Physicia	1	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	SERC	15		Interval Between Onset and Death
/ /Medica Examine		resulting in death)	consequence of):			
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cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
BOX 68/60, eath certificate be executed attending physician and for use as the burial-transit	-		consequence of):			
687 ifficate to g physical	dica	d				
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Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medica	in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown			Month	Day Year
IS, P.C		Part II. Other significant conditions contributing to death but	not resulting in the underlying caus	e given in Part I. 23e	e. Did tobacco use contribute t	o the cause of death?
COrdS w requires been sign should be	d by	ACUTE RENAL	FAILURE		1  Yes 2 No 3 P	robably 4 Donknown
ecords, law requires the as been signed 2 should be contact.	Completed	ANEMIA		24a	. Was an autopsy 24b. Were a	utopsy findings available completion of cause of
	Com			10	performed? death? Yes 2 No 1 Yes	_/
VITAL HEC sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		26. Place of Death (Check		
g Phys er this eral dir	n: To	1 Yes No 1 Impatient 27. Manner Death 28a. Date of Injury		4 Nursing Home 5L	Residence 6 Other (Spescribe how injury occurred	ecify)
Vatending F death. ctor: After y the funera	atio	1 Natural 5 Pending (Month, Day ) 2 Accident investigation	Year) Injury M	Vork? 1 ☐ Yes 2 ☐ No		
UNISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury building, etc.	<ul> <li>At home, farm, street, factory, of (Specify)</li> </ul>		ation (Street and Number or R or Town, State)	lural Route Number,
Spital nours ineral		29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death occurred at t	ne time, date and place, and due	to the cause(s) and manner a	s stated.
the Ho iin 24 I the Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of e and manner state	ed.			
Vaiti Sor	2	29b. Signature and title of certifier	29c. Li	cense number	29d. Date signed (Mon	th, Day, Year)
atIVA		30. Name and address of person who completed cause of dea	th (Item 23a) (Type, Print)	60313	1 3/4/0	8
1.80		M.THIMM ARLAYAPPA		ERN SHORE I	DR. SALLSKU	CY MDZ1800
	tate	31. Date filed (Month, Day, Year) 32. Pegistrar	s Signature			
Regis	trar	MAR V J 2000	o so proside			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For Stete Registrer	State o	f Maryland	-	artmen rtificat			ind Me		iene	08	08948
п	Physici	an	1. Decedent's Name (First, Middl							2	Date of Dea Month	Day	Yeer	3. Time of Death
	/Medic		WILLIAM	ALFRED	VANCE						larch	7, 20		11:15A ^M
	Examin	er	4a. Facility Name (If not institution		mber)				Location o			4c. Count		
			938 Pope A	Avenue 6. Sex	7. Age (In yrs. la	et hirthday)		gers 1 Year	If Under 2		Date of Birth			gton
	Funeral Director		218-24-7563	1 <b>∑</b> M 2□F	75	Yrs.	Months	Days	Hours	Min. Au	Date of Birth (Month, Day GUST 2	1932	Mai	place (State or Foreign htry) Cyland
			Usual Residence of Decedent								J	,		- <del> </del>
	irylan show	_	10a. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
	8a-f	octo		ington	<u></u>	lagers								1X Yes 2 No
	with th	Funeral Director	10e. Street and Number				10f. Zip				1	0g. Citizen of		•
	s 23	a a	938 Pope Avenue		edent Ever in U.S	12.1		21740		in? (Consi	fu Van au bla		S. A.	
10	fter dee	FLE	11. Marital Status  1 □ Never Married 2 Married	Armed Fo	rces?	. 13.	f Yes, spec	offy Cubar	n, Mexican	, Puerto Ri	fy Yes or No- can, etc.)		ck, White,	
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21215-0036	d within 72 hours after deeth with the Maryland liene. r then "neturel", or iteme 23a or 28a-1 ehow The Medical Examinar must be rediffed at	Completed	15. Deceden	t's Education st grade completed)		16a. Deced	dent's Usua	al Occupa	ition	of working		16b. Kind of B	usiness/In	dustry
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72	9 0 6		17 Forbada Nama (First Middle	( ant)		Ма	chini		40 14-11-	da Nama /				rage Doors
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7	s 1 and 2 should by I Health and Menta Item 27 is marked other traumatic e	ဥ	19a. Informant's Name/Relations		varice	19b. Mailir	na Address	(Street a	Elva		May Boute Number	, City or Town	lson State Zir	Code)
₹	and 2 : ealth ar n 27 is		Juanita M. Vand									, Mary		21740
ē,	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nan	ne of		Dat		20c. Location		
٤	Pages nent of int: If it		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State UECaT	retEra Wiff	"Mem"	""HK"	"   C	)3-12-	-08 F	lagerst	own,	Maryland
Baltimore,	permit. Pag Depertment Important: I eny Injury o		21. Signature of Funeral Service	Licensee		22	. Name an	d Addres	s of Facility	y _	_			
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death, ach line.	Do not ent	er the mod	e of dying	, such as	cardiac or r	espiratory arr	est.	,	Approximate Interval Between
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P.0.	that the de ned by the a detached f		Part II. Dther significant condition	ons contributing to de	eath but not result	ing in the ur	nderlying c	ause aive	n in Part I		23e Did to	hacco use con	tribute to ti	he cause of death?
Records,	8 50	d by	HTN	,		,		aass g.vo.	., ., .			es 2 🗆 No		pably 4 Unknown
9	w require been si should I	Completed									24a. Was a	n 24h	Were auto	psy findings available
Re	0 5 0	m C									autops	ned?	prior to co death?	mpletion of cause of
tal	ician: Th certificate rector, pag	0	25. Was case referred to medical						26 Place	of Death #	1 Yes		1 🗌 Yes	2   No
<u>&gt;</u>	Physician: r this certific rat director.	To B	examiner? 1 ☐ Yes 2 █�o	Hospital: 1 🔲 I	npatient 2 E	R/Outpatien	t 3 DO	Otho	-			ence 6 🗆 Oth	er (Specif	(v)
0	ng Ph fter th nerat		27. Manner of Death 1 Matural 5 ☐ Pendin	28a. Date (	of Injury 2 th, Day Year)	8b. Time of Injury	2	8c. Injury Work	at			w injury occur		
Sio	Attending r death. ector: After by the funer	catl	2 Accident investig	gation			М	1 🗆 Y	'es 2□N	10				
Division of Vital	after death Director:	Certification:	3 Suicide 6 Could i	ined 28e. Place	of Injury - At homing, etc. (Specify)	e, farm, str	eet, factory	, office		28	f. Location (Si City or Town		oer or Rura	al Route Number,
L	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death or To the Funeral Directors After this certific completely filled in by the funeral director.		29a, Certifier 1 Certifyin	g Physician: To the	host of my knowl	ledge deet		at the tree	n det-	d ele	d due to the			
	e Hos	edical	(Check only 2 Medical one)	examiner: On the ba	asis of examination	n and/or inv	estigation,	in my opi	inion, deat	h occurred	at the time, d	ate and place,	anner as s and due to	tated. the cause(s)
	within To th compl	Me	29b. Signature and title of cortifie				29c	. License	number		2	9d. Date signe	d (Month,	Day, Year)
			) Cano	ahm	SL		I	DOC	300	23:	3	3/0	7/2	500 8
			30. Name and address of person	who completed caus	e of death (Item 2	23a) (Type,	Print)					-		
0	4-641		Shahid Mahmod	od MD 58	0 Northe	ern Av	enue,	. Hag	ersto	own, M	Marylar	nd 2174	0	
	Sta Registr	_	31. Date filed (Month, Day, Year)  MAR 1 (	1 3	sistrar's Signatu	re	Could							
	- registi		JA FIMIL	1 LUUG	17	( Jan 19 )								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State of	Maryland		artment o rtificate			and M	-	giene Reg. No. 2	008	0894			
Physician /Medical Examiner	4	Decedent's Name (First, Middle     FREDERICK LEV     A. Facility Name (If not institution	I WELLER	nber)		4b. City, To	wn, or L	_ocation o	of Death	2. Date of De Febru	any 27	Year 200				
Funeral Director		Memoral 5. Social Security Number 216-09-3259	1. Sp. + a 6. Sex 1. M 2□ F	7. Age (In yrs. In	ast birthday) Yrs.	If Under 1 Months E	Year Days	If Under a	24 Hrs. Min.	8. Date of Birn (Month, Da	y, Year)	9. Birth	pplace (State or Foreigntry)  W YORK			
with the Maryland a or 28a-f show be notified at	-	Usual Residence of Decedent 10a. State 10b. County 10b. TAL	вот	10c. City	, Town or Location <b>EASTON</b>						10d. Inside City Limits <b>1X</b> Yes 2 □ No					
<u>a</u> is 23 ⊒		10e. Street and Number 501 DUTCHMA	n's lane			10f. Zip Co		2160	L		10g. Citizen of What Country?  USA					
urs after of all; or iter examiner.		11. Marital Status  1 □ Never Married 2 □ Marri 3 🛣 Widowed 4 □ Divorced  15. Decedent (Specify only highes	Armed For 1X Yes If Yes, Give Year or Da	2 □ No e	16a. Dece	Was Deceder If Yes, specify  1 ☐ Yes 2  dent's Usual ( kind of work of DO NOT use i	) No Occupat	Specify:			14. Race - American Indian, Black, White, etc.  Specify: WHITE  16b. Kind of Business/Industry					
led within 72 ho lygiene. her than "natur her, the Medical B rt, the Medical B		Elementary/Secondary (0-12)	College (1-	4or 5+)		UPERVI	SOR-	-EMPI	LOYMI	INT			RNMENT			
Mental Hygis arked other i aric event, tr		17. Father's Name ( <i>First, Middle,</i> <b>LEVI H. WELLE</b>					1			(First, Middle, BETH SH		name)				
z should be z should be and Mental Is marked or raumatic ev		19a. Informant's Name/Relations								l Route Numbe			ip Code)			
permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tr.	W. THOMAS FOUNTAIN/PER. REP. 16 S. WASHINGTON ST., EASTON, MD 2160  20a. Method of Disposition  1										ON, M	ARYLAND				
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thin 24 hou o the Fune ompletely fil		29a. Certifier  (Check only one)  1 Certifyin  2 Medical	<b>g Physician:</b> To the l <b>Examiner</b> : On the ba and mann	sis of examinat	vledge, deatl ion and/or in	occurred at vestigation, in	the time my opi	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)			
		29b. Signature and title of certified	o MD				ra .	number 44	88		29d. Date sig		- ZCO 8			
+VA	1	30. Name and address of person Benneth	who completed cause	of death (Item		S. W	ash	inst	07	5+ ,	East	00 /	MD ZILC			
State Registrar		31. Date filed (Month, Day, Year)		gistrar's Signat		and a										

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. State Amededed items#24a&24b,3.14.08Gertificate of Death 1. Decedent's Name (Past, Middle, Last) Reg. No. 2. Date of Death Month $\rho 2$ Jack Vincent Wootten, Sr. 2008 800 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Centh PAINSULA REGIONAL MEDICAL 54/1364M NICIMIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 2, 4 Month Day, 1 Une 2, 5 Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Months 1 ▼ M 2 □ F 221-20-7730 74 unknown Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits DE Sussex Greenwood 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12090 Clardon Farm Lane 19950 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 21☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Farmer</u> Grain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester Wootten Daisey Hudson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. I Marie Hall (Daughter) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Line Cemetery 2-23-2008 4 □ Donation 5 □ Other (Specify) Delmar, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street Hannigan, Short, Disharoon F. H 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Approximate Interval Between Onset and Death oronary Due to (or as a consequence of): HIN for as a consequence off. Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown embolis 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☒Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show must be notified at

the Medical Examiner

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'natural",

Is marked other than

27

Department of Health Important: If item 27 any injury or other tr

Pages 1 and 2 should be in nent of Health and Mental

with items 23a or

21215-0036

Maryland

Director

Funeral

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Completed

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burial-tran and physician the for use ed by the a detached f ate has been sign page 2 should be certificate

Examiner Certification: To

Physician/Medical Be Completed by

funeral director After this filled in by completely

requires that the death certificate be executed or Attending Director; hours after within 24 hours at To the Funeral D Hospital

Division or Vital Records, P.O. Box 68760,

Physician:

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions desired leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 mon 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. e ffusion 24a. Was an autopsy performed? Stanou 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/21/08 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) Ellega 100 E 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

State Registrar

MAR 0 5 2008

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar" or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at any pines. Baltimore, Maryland 21215-0036

**Physician** 

**Funeral** Director

/Medical

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

SH6+1 Sta Registra

ner	4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, or	Location of Death		4c. County of D	eath		
	Washington County H	lospital		Hager			Washing	gton		
	234-14-3139	7. Age (In yrs. la	as <i>t birthday)</i> 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 1,	^{Yea} r) 1920 Ve	Birthplace (State or Foreign Country) Crmont		
	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Loc	eation				10d. Inside City Limits		
tor	Maryland Washingto		Lliams					1 ☐ Yes 2¾ No		
<b>Funeral Director</b>	10e. Street and Number 16505 Virginia Aven			10f. Zip Code	705	1	0g. Citizen of What			
ra E					795 ————	U.S.A.				
y rune	1 □ Never Married 2 🕱 Married	Was Decedent Ever in U.S Armed Forces? 1 TxYes 2 ☐ No If Yes, Give W•W•I Year or Dates:	li li	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 ▼No	spanic Origin? (Spen, Mexican, Puerto Specify:	14. Race - American Indian, Black, White, etc.  Specify: white				
ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Education		201240-10	ent's Usual Occupa				white		
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5	Elementary/Secondary (0-12)	College (1-4or 5+)	sup	erintend	ent	I .		department		
,										
2	Chester Pi		1			Mary 1				
	19a. Informant's Name/Relationship (Type.  David Wade - son	Print)					City or Town, Stat			
	20a. Method of Disposition	20b. PI	L B325 ace of Dispos	Manor Cl sition (Name of natory or other place	nurch Roa	d, Boons	Sboro, Ma 20c. Location - City	ryland 21713		
	1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo	oval from State		natory or other place n Cremato	Marc		•	n, Maryland		
	21. Signature of Funeral Service Licensee	0	22.	Name and Address	s of Facility	Minnich	Funeral	Home		
	Violet B. Co.	eki.	41	5 East Wi	lson Blv	d., Hage	rstown, l	Maryland 2174		
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-	IF FEMALE:									
	23c. 1 23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery  Month Day Year								
r ily siciali/ wiedical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	WOITH	Day real							
	Part II. Other significant conditions contribu	uting to death but not resul	Iting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contribute	e to the cause of death?		
	(erdione	anethy	\	, 0	·	1 □ Ye		Probably 4 Onknown		
combiered		( 1				24a. Was ar	24h Were	autopsy findings available		
1						autops perforn	prior ned? death	to completion of cause of h?		
0	25. Was case referred to medical				26. Place of Death		! <b>₽</b> /No   1∐Y	Yes 2□No		
	examiner? 1 ☐ Yes 2 ☐ No	oital: 1⊒Impatient 2□E	R/Outpatient	Otho	r·		nce 6 ☐Other (S	Specify)		
			28b. Time of Injury	28c. Injury Work	at :		w injury occurred	фону		
	2 Accident investigation	(Memm, Day Year)	,,		es 2 □ No					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 2	8e. Place of injury - At hon building, etc. (Specify)	ne, farm, stre )	et, factory, office	1	28f. Location (Str City or Town		r Rural Route Number,		
	29a. Certifier Certifying Physicia	an: To the heet of my know	dodgo dogth	COOLERAND At the Aire	o data and place					
	(Check only 2 Medical Examiner:	an: To the best of my know On the basis of examination and manner stated.	on and/or inv	estigation, in my op	e, date and place, pinion, death occurr	ed at the time, d	ate and place, and	r as stated. due to the cause(s)		
	29b. Signature and title of certifier	1		29c. License	number	29	d. Date signed (Me	onth, Day, Year)		
	Julen 1	Cha	RN	170	23623	r	MADEL.	1 7 20US		
	30 Name and address of person who comple		23a) (Type, F	Print)	1		10 11	1		
	Frederic H	MSS 111 m		HOWLE	hud (	more	w te	gerchown		
	3 VDate filed (Month, Day, Year)	32. Registrar's Signatu	ure	1		•		mi		
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21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Na. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ARLINGTON WILSON WALLS 7008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner stertour If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 XM 2 ☐ F Director 220-34-9345 94 7/9/1913 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director QUEEN ANNE'S SUDLERSVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 105 LEAGER RD. 21668 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify: δ 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Bone. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 FARMER AGRICULTURE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELLA LEAGER SAMUEL H. WALLS ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 105 LEAGER RD. SUDLERSVILLE, MD 21668 LESLIE WALLS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/11/08 ASBURY CEMETERY MILLINGTON, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiagon respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequent **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trans attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autopsy 2□ No 1 ☐ Yes 2 To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ER/Outpatient 3□ DOA 1 | Inpatient 1 ☐ Yes Certification: To Manner of Math 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12 30/Name and address of person who mpleted cause death (Item 23a) (Type, Print) 31. Date filed (Mon trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NDERSON **Physician** Month 2008 0 3 /Medical 4b. City, Town, or Location of Death Eacility Name (If not institution, give preet and number 4c. County of Death Examiner tacility Vursina timore Age (In yrs. last birthday)
Yrs. If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** 212-36-8965 Days 1 □ M 2 💢 F Months Director Usual Residence of Decedent State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Baltimore 1 Wes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ISA 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 250 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) auard 17. Father's Name (First, Middle, Last) UNK Be 18. Mother's Name (First, Middle, Maiden Surname) Unk and 2 should be Sa. Informant's Name/Relationship (Type. Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Baltimore, MD 21201 Johnson seorge 20a. Method of Disposition 20b. Place of Disposition (Nature of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Baltimore, and .20.08 reen 21. Signature Funer Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death Day 1 □ Yes 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform certificate Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No this Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Atlending Injury 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 2 AQA IN 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

19-19-18-1

MAR 2 0

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Etta L. Brown State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 15, 2008 Medical Examiner ETTA L. BROWN 1421 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 815 Winters Lane #204 Woodlawn **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Foreign Country) Months Hours Director 228-46-6706 5/27/1936 1 M 2XXF 71 Usual Residence of Decedent 'n 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MD BALTIMORE CATONSVILLE 28a-f show 1 Yes 2 X No . Pages 1 and 2 should be filed within 72 hours after death with the Maryland irrent of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 WINTERS LANE, #204 21228 TISA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes 3 X Widowed BLACK Yes, Give Year Yes 2 X No specify: 4 Divorced Specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12TH 2 HOMEMAKER DOMESTIC 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LONNIE HYMAN KATIE VANN å 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY FULMER / STEPSON 2229 HAMPTON STREET, COLUMBIA, SC 29204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ROCKVILLE CEMETERY 3/26/08 LYNBROOK, NY 4 Donation 5 Other Specify: 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Port I. Enter the assase, or complications that caused the death railine. List only one cause on each line. Approximate Interval not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease diate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last executed Physician/Medical e attending physician for use as the burial -UNPENDED AMENDED death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Fetal death Month Dav Year past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. δ. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be examiner? Hospital: Other, Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes ۵ neral Director: After of filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural within 24 hours after death.

To the Funeral Director: Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 16, 2008 O.C.M.E. 17740 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 31. Date filed (Month)

State Registra

Day Year)

2008

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fb 9878 4-10-08 yt. State of Maryland / Department of Health and Mental Hygiene 1 - StateAmend 19b per FH g878 4/3/08 amh Certificate of Death AROK Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month MARCH 2008 PAULINE LISA BATTIESTE 2:35A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A JOSEPH RICHEY HOSPICE BALTIMORE CITY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 12/13/1938 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Months 437-56-7994 69 Yrs. Director LOUISIANA Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show ns 23a or 28a-f show must be notified at BALTIMORE CITY XXYes 2 □ No MD N/A Director 10e. Street and Number 10f. Zip Code 817 10g. Citizen of What Country? 1100 BOLTON STREET, APT. A17 21201 items 23a USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Black, White, etc. 72 hours after 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 "natural", or BLACK 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) t of Health and Mental Hygiene. College (1-4or 5+) DISABLED DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY BATTIESTE HERMAN ASBERRY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 BOLTON STREET, APT A17, BALTIMORE, MD 21201 WENDELL HARRISON / SON 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any injury or ot 3/25/08 WINDSOR MILL, MD KING MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD 23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart factore. List only one cause on each line.

Immedia: Lause (Final Approximate Interval Between Onset and Death CARCHAROMA **Physician** disease or condition resulting in death) ar COLON 1-24RS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last and physician an certificate be exec Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1□Yes 2⊠No ed by the detached 9□Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA nours after death.

neral Director; After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOROWIE DOLTON

Registrar

State

31. Date filed (Month, Day, Year)

MAR 20

3/18/108

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:05PM **Physician** Holen 3008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA 00 Imstead Baltino 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Year 5. Social Security Number **Funeral** 1 M 2 F 86 Months 18/192 Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shoν Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 natural", or 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene.
is marked other than "natur Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဥ permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau paltimure, MD 21210 Dr. Elgene Brode 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 19/08 Baltimure, MS 4 ☐ Donation 5 ☐ Other (Specify) Vougho C. Breene Juneralsius. 21. Signature of Funeral Service Licensee disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Leontres Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has l 1∐ Yes 2 1400 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Defection 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To neral Director: After this y filled in by the funeral di 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACT MD 21202 STYAIN FRANCIS X. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician JORR /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner View trodel edoe If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Hours 1 X M 2 □ F C 215-20-71 1938 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ▼ No Director MD Frederick Frederick 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ō be 21701 USA 700 Toll House Avenue 23a must Funeral 14 Race - American Indian, items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status "natural", or item edical Examiner n Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: ■ 72 hours after 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No white Specify: <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced **'**52-55 Completed บท other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. 8 laborer marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) with and Mental F. Be Jacob Ellwood Bittinger Jenny Mae Shrout 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and and and and and and and 27 is 223 N. High Street Martinsburg, WV 25404 Jane Bittinger/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Ştate 4 Donation 5 ☐ Other (Specify) 21. Signature of Fundamental vio State and Address of Face board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signated the Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 Yes 2 No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signat re and title of certifier 29d. Date signed (Month, Day, Year) D0060417

Registrar

State

Johnson Dr, Frederick MB 21702

MD

Shamas

2. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

shah

31. Date filed (Month, Day, Year) 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Phys	ician
/Me	dical
Exan	niner

**Funeral** Director

r than "natural", or items 23a or 28a-f show the M dral Examiner must be notified at

Maryland 21215-0036 12 should be filed what and Mental Hygien 7 is marked other the Injury or other traumatic event, permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau Baltimore,

BOSLE

SLENN

**Physician** /Medical Examiner

be executed sician and burial-tran attending physician as the use lor detached certificate Physician: filled in by the funeral After 1 Hospital or Attending death. after death

P.O. Box 68760,

Records,

or Vital

Division

Days 1 X M 2 □ F 88 577-22-0909 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County MD Baltimore Sparks 10e. Street and Number 10f. Zip Code 14911 Thornton Mill Rd. 21152 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector 17. Father's Name (First, Middle, Last) Anna Webster Bosley Matthews 19a. Informant's Name/Relationship (Type. Print) Glen Miles Bosley, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 3/20/08 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bosley United Meth. Church Cem. Signature of Funeral Society Licensee Michael J. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PULMONARY (saddle) EMBOLISM Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes Hemorrhagic ischemic enteritis with bowel adhesions. 24a. Was an Staph aureus sepsis. Cardiomegaly.
25. Was case referred to medical examiner? 1√ Yes 26. Place of Death (Check only one) 1 ☐ Yes 2√∑ No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 D28885 3/17/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard L. Siegel,M.D.,6701 N. Charles Street,Balt.MD 21204 32 Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear 20:35^M Glenn Miles Bosley, Sr. 2008 MARCH 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) MD April 3, 1919 10d. Inside City Limits 1 ☐ Yes & ☐ No Director 10g. Citizen of What Country? USA Funeral 14. Race - American Indian, Black, White, etc. White þ Specify: Completed 16b. Kind of Business/Industry Balto. City Health Dept. 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9666 Horsham Dr., Laurel, MD 20723 20c. Location - City or Town, State Sparks, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Approximate Interval Between Onset and Death Terminal Examiner Physician/Medical 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? þ 2√ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28d. Describe how injury occurred Certification: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) MAR 2 0 2008

To the Hospital within 24 hours a To the Funeral E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For amend #10f Per FH G87/3	/and Depa /20/08 Depa /er	rtment of F	lealth and N Death	ental Hyg F	giene leg. No.200	08 08959					
4	Physici /Medic		1. Decedent's Name (First, Middle, Last) Walde Conwell	e Conwell				2. Date of Death  Month  Dary  Vear  N  N  N  N  N  N  N  N  N  N  N  N  N						
5.		4a. Facility Name (If not institution, give street and number) SUMMIT PARK NURSING & REHABILITATION CENTER  5. Social Security Number 6. Sex 7. Age (In yrs. last)				SVILLE  If Under 24 Hrs.	O Date of Birth		TIMORE					
E.	Funeral Director		212-20-6123	82 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 7/15/1	, Year) .925	9. Birthplace (State or Foreign Country) TENNESSEE					
	Maryland a-f show ified at	tor	10a. State         10b. County         10c. City, Town or Location         10d. Inside City L           MD         BALTIMORE         REISTERSTOWN         1 □ Yes 2 €											
d 2121	th with the 23a or 28 ist be not	al Director	10e. Street and Number  38 BROOKEBURY DRIVE, APT. 1	С	10f. Zip Code 2123	6 <b>21136</b>		10g. Citizen of What Country? USA						
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married  2 □ Married  1 □ Yes ♀ ↑ No If Yes, Give Year or Dates:	l1	Was Decedent of H f Yes, specify Cuba I □ Yes 2√ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: BLACK						
	within ene. than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12TH	(Give life. D	OO NOT use retired	durina most of work	ing	16b. Kind of Business/Industry FEDERAL GOVERNMENT						
	be file tal Hy dothe event,	To Be C	17. Father's Name (First, Middle, Last) LESTER FORD-BEY			18. Mother's Name	e (First, Middle,	flaiden Surname)						
	ges 1 and 2 should be it of Health and Menta if item 27 is marked or other traumatic ev		19a. Informant's Name/Relationship (Type. Print)  VALENCIA SKETERS / NIECE			and Number or Rur			tate, Zip Code) 21136 STOWN, MD					
Baltimore,	Pages 1 and Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical Herical He		20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem ODD FELLC	sition (Name of natory or other plac DWS CEME)	TERY 3/2:	Date 2/08	20c. Location - C	ity or Town, State					
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Euneral Service Licensee	Sur 46	Name and Addre	ss of Facility HO	WELL FUN	VERAL HON	Æ 21207 DRE, MD					
	Physician		23a. Pan En er the discrete, or complications that caused the shock, or heart fair re. List only one cause on each line. Immedia — ause (Final disease or condition	death not ente	er the mode of dyir	ng, such as cardiac		rest,	Approximate Interval Between Onset and Death					
8760, <	Cate be executed bhysician and the burial-transit	dical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
.O. Box 6	requires that the death certifica een signed by the attending pt hould be detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify) _	1		23d. Date Mont	,					
Ω.	quires that n signed b ıld be deta		Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause giv	en in Part I.		_	ute to the cause of death?					
Division or Vital Records,	The law ate has b page 2 s	Completed	fucuoran x E	perfor	utopsy prior to completion of cause of death?									
or Vita	Physician: The la r this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient		4 Nursing Ho		<i>ne)</i> ence 6 ⊡Other	(Specify)					
ision o	To the Hospital or Attending Physician: white 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be		100	Yes 2 □ No		Describe how injury occurred						
<u>.≥</u>	pital or A		4 Homicide building, etc. (8						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	(Check only one)  2 Medical Examiner: On the basis of examiner stated  29b. Signature and title of certifer	amination and/or inv	estigation, in my o	ppinion, death occur	red at the time, o	date and place, ar	nd due to the cause(s)					
	T Will		290. Signature and the dicertifier					MANCH 17th 2008  307 BALTIMONE WAS						
	6		30. Name and address of person who completed cause of death		Print)	UCENS A	WE	307 6	ALTIMONE Mes					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Pigistrar's MAR 2 0 2008		ades									

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 08960 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year CCIDE M ATIM. 20500 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chesapeake Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Feb 2, 1946 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 3 F 62 Yrs. Director 217-44-9599 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Director Maryland Prince Georges 1 ☐ Yes 🏖 ☐ No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or items or or other traumatic event, the Medical Examiner must be not or other traumatic. 15908 Pinecroft Lane Funeral 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ģ Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Work Government Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thomas Meany Helen Elizabeth Boyle ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron D. Berger, Son 301 Sarah Lane Lawrenceville, GA 30045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/20/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor ^{23. Name and Address of Facility of Maryland, Inc.} 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LINUX icars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Influry that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed; 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) N DSQ 15 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **≯** Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature of title of certifie 29c. License number

10

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person

DICUM

400 1 6 KLG MAR 2 0 2008



repleted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 3119108

SLITE 300 Dagions

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 15 2008 10:10 P M Edna Chenoweth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Lutheran Village Carroll County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 4 1908 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 ☐ F Baltimore Maryland 213 54 1557 99 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Carroll County Maryland Carroll Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21158 201 St. Mark Way Apt. 103 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Housekeeping-Own Home Homemaker d 2 should be filed with and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lottie Schmuf William Menke ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau 3504 Back Point Ct. Unit 2 C Abingdon, Maryland 21009 Carlton D Chenoweth 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 ☐Removal from State Gardens of Faith Cem. March 20 2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Service Licen 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hnowe Re /Medical Due to (or as a consequence of) Examiner torl Sequentially list conditions, it is a light control of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transi Due to (or as a consequence of) Box 68760. physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 3 ☐ Probably 4 ☐ Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autonsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 12 Certifying Physician: 2 Medical Examiner: 0g o the best of my k the basis of exami 29a. Certifier Medical nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce 137949 Mench 17, 2008 m 23a) (Type, Print) 30. Name and address of berson was leted cause of death (N alres 31. Date filed (Month, Day, 3. Registrar's Signat State 2008

DHMH 17 Rev 1/2001

Registrar

MAR 20

HENOWETH

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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Jannie Mae Clark 2008 5:25 a March 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1514 King William Drive Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 247-88-5351 1 🗆 M 73 Min. Director 09/28/1934 SC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at SC Clarendon Manning 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29102 731 Branchview Drive USA death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 1000c. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 XNo **Black** 1 ☐ Yes 2 No Specify: þ Specify 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry Worker Hote1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Hammerr Ester Mae Pearson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4903 Reisistertown Road, Baltimore, MD 21215 Tammy Daley / Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date UNLII. 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Caroline Cemetery Davis Station, SC 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 21. Signature of Funeral Service Licenses 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed for use as the burial-transi and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. I signed by the a d be detached for 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 No r 1 | Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation М 1 ☐ Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 7.55 AM James Carroll MARCH 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSP ITAL MANEJ BAZIMONE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Jan 14, 1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 UnK 6 Sex **Funeral** Months Days Hours 1 ₹ M 2 □ F Yrs. 228-30-4865 79 **Director** Usual Residence of Decedent 10a. Stateunk 10b. County unk 10c, City, Town or Location unk 10dn I side City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk unk USA Funeral unk 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: unk 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk Department of Health and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event any injury or other traumatic event 4000. traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Agnes Hospital 900 S. Caton Avenue Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5⊠Other (Specify) in state 21. Spreature of Funeral Sprice Licensee State and Addess of a Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPSIS **Physician** /Medical Due to (or as a consequence of): Examiner END STAGE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DEMENTIA that the death certificate be executed END STACIE attending physician and for use as the burial-trar Due to (or as a consequence of): ullens DE wis, MIS Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPER TENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed PERIPHERAL 24a. Was an VASCULAR page 2 s autopsy performed? (es 2 No certificate 1□ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1/ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Division or Vital Records, P.O. Box 68760 Hospital or Attending

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 20 2008



AT CONDING

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fig. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

8 4351 MC

PLACE FUITE

29d. Date signed (Month, Day, Year)

St sacrimone MD 21217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year CDATES Month **Physician** DORIS 11:48 AM Malch 16 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randalls town HOSPITAL YOTH WEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. **Funeral** 22.8723 1□M 22F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 271s marked other than "natural" or them 271s marked other than "natural". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Owings Mills Owings Mills MD. 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21117 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊆ U No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: 3 ₩idowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) touse Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) E. Smith Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North Hollins Ferry Glen Burnie, Uld 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Balto. HD Loudon Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility reene Funeral Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ake Bultimore, Ulb. 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner הייכו ניויז כפתווכate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ZUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2☑No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director... 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Harch, 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Abdellah Kafrouni, 5401 Old Court Road, Randalls town, MD 21133 Kafrouni 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 20 Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 2008 **Physician** March 17, Gordon Leonard Dell 6:20 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center @ GBMC Towson Baltimore 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months September 9, 1936 **XX**M 2□ F 213-34-4690 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 Tyes 2X No Director Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 514 Cedar Avenue 21221 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Aves 2 □ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify.White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No þ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

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1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? Yes 2 Wo certificate 1∐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Wesplus 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1) Natural 5 Pending investigation ne Hospital or Attendi n 24 hours after death. he Funeral Director: A pletely filled in by the fu 1 Yes 2 No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral C 29a. Certifier 😂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Marlon

31. Date filed (Month, Day, Year), 2008

Apren J. Commes un

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles

52. Registrar's Signature

29c. License number

D 58303

TUNSON MO 21204

29d. Date signed (Month, Day, Year)

March 17 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DIXOK MARCH 2008 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and numbe BALTIMORE BON SECOURS If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number Months Days 1 **X**M 2 □ F 219-52-9282 MD Dec. 4, 1949 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21223 229 N. Mount Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: **Black** 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) laborer construction company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Morton George Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 229 N. Mount Street; Baltimore, Maryland 21223 Eugene Morton / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 03/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery Baltimore, Maryland 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 23a. Part1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month 4☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performed 2 11 10 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No (Specify)

**Physician** /Medical Examiner

physician

certificate

this

After t

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filled in by

completely

Medical

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

be executed and

Box 68760,

P.O.

Division or Vital Records,

Physician

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or edical Examiner must be

er than "natur the Medical J

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Mones.

Director

Funeral

Completed by

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore.

burial-trar Physician/Medical the use ρ ed by the a þ Completed page 2 Be Certification: To funeral

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

6 ☐ Could not be

determined

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5	Ho	spital:	1 Dinpatient	2 🗆	ER/Outpatient	3 🗆 [	OOA	Other:	1 ☐ Nursing H	ome	5 ☐ Residence	6 ☐Other
5 ☐ Pending investigation	1		Date of Injury (Month, Day Yo	ear)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 🗆 No	28d.	Describe how inj	ury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0030355

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUZ M. N KOSITA

BON SECOURS HOSPITAL

31. Date filed (Month, Day, Year) State

27. Mann Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

2. Registrar's Signature

Registrar

State Registrar Stroud

Nicole

31. Date filed (Month, Day, Year)

Sinai

32. Registrar's Signature

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JACK Μ. **FYOCK** March 2008 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 052 ti 715 ranklin Mare mare If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day) Birthplace (State or Foreign
Country) **Funeral** Hours Months Days Min. 1**½** M 2□ F 212-30-7806 75 Yrs 3-5-1933 PENNSYLVANIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. Count BALTIMORE ROSEDALE MD 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. ò Examiner must be 1210 GETTIG ROAD 21237 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 □ No
If Yes, Give
Year or Dates: 1954-6 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à XXWidowed 4 Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER DAVIS & TRANSFER 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHESTER **FYOCK** LONA (SMITH) ဥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTIN FYOCK/SON 1210 GETTIG ROAD ROSEDALE, MD 21237 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State OAKLAWN CEMETERY 3-22-08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE 21237 ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MetaStatic Itde disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy perform 2 A No Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29b. Signature and Alle on certifie 29c. License number 29d. Date signed (Month, Day, Year) D0062572 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of pe

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAR 2 0

90000

2008

Registrar's Signature

Square Dive Baltimore

State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year FOOTE HERBERT 0 1025 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1mms DOLTIMORE N If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Hours 220.20.2715 82 Director 01-14. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 'natural", or items 23a or 28a-f shov dical Examiner must be notified at Baltimore 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21223 amonds on Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore amtenance Supervisor Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Foote 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Samuel SEM Long Lake Keisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3.20.08 Woodlawn, MD. 4 ☐ Donation 5 ☐ Other (Specify) Wood lawn 21. Signature of Funeral Service License Name and Address of Facility reene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto - MD. 21229 ltimore Nat'L Pike Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 45 MIN Hemorrhab ULMONARL /Medical Due to (or as a consequence of): Examiner DIOPATHIC Ulmonare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed ician and burial-tran Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 □ Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2**X** No Vital 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 X ER/Outpatient 3 □ DOA Medical Certification: To Division or this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESWARS South 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 **Physician** 17: 40 PM Andrea Hamm 2008 /Medical 4c. County of Death 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 216.90.6075 1□M 2XF 51 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or Solar Circle # B 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 1 ☐ Yes 2 No Specify: Black Specify. ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical marked other than -udent 18. Mother's Name (First, Middle, Maiden Surname) and 17. Father's Name (First, Middle, Last) 2 should be finance and Mental H averne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print Kichmond Brother 511 onley Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition ō Important: If It any injury or o once. Marzz Burial 2 ☐ Cremation 3 ☐Removal from State RIVERVIEW CEMETER 4 □ Donation 5 □ Other (Specify) 2008 21. Signature of Funeral Service Licensee North Avenue Eral 23a. Part1. There the disease, of complications that call ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiorgan failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t Examine be executed bacteriemia Due to (or as a consequence of) burial by Physician/Medical the Box IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) by the a 1 ☐ Yes 2 ☐ No 9 4 nknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Completed Hepatitis 24a. Was an T Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autops, performed? Ves 2☐No Drug abuse certificate Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 4mpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes P o this After thi funeral ( 28a. Date of Injury 28b. Time of 27 Manner of Death 28d. Describe how injury occurred Certification: 1 Alatural (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident To the Funeral Director; / completely filled in by the f 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ò within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Malinia

Registrar DHMH 17 Rev 1/2001

State

5601 Loch Raven

31. Date filed (Month, Day, Year)

**ORIGINAL** 

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alex Malinin,

32. Registrar's Signature

Blvd.

03.17.08

MD.

21239

MD

Good Samantan History

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Depedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 10:20 AM 0 MARCH 2000 0 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner on thwest MANIL KA) 8. Date of Birth 1/2/29/33 Age (In yrs. last birthday) 74 Yrs. If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 □ F Months Hours 213-32-9932 NORTH CAROLINA Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at PIKESVILLE 1 ☐ Yes 2 No BALTIMORE MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a or Examiner must be 21208 USA 2 SALEM COURT Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No BLACK" Specify: ģ 3 ☐ Widowed 4 🕅 Divorced "natural", Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry VILLAGE nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) CASHIER/COOK FOOD CENTER 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES DUNCAN LEWIS ESSIE B. CRAWFORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SALEM COURT, PIKESVILLE, MD 21208 KIMBERLY HOWELL / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3/25/08 WINDSOR MILL, MD KING MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD se, or complications that caus List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate ause (Final disease or condition resulting in death) Physician DIN A From /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir certificate be executed the burial-transi Due to (or as a consequence of): Box 68760. physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No Division or Vital 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Depatient ၉ 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After To the Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Court

019

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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Steven tullor

31. Date filed (Month, Day, Year)

MAR 2 0

2008

		For State Registrar	State of Mar	yland /		ent of Ho cate of D			giene Reg. No. 200	8 0897	2
Physic /Medi		1. Decedent's Name (First, Middle, Las Gary Dale	Hippeare	1				2. Date of De Month	Day Ye	3. Time of Death	1
Exami Funeral Director	ner	4a. Facility Name (If not institution, give SACT: MOPE WAS S. Social Security Number 6. Sr 225-46-4312	PX 7. Age	IN yrs. last b	CENTY Dirthday) If L	*	Location of Death  HOUS  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATION OF DEATH  LOCATIO		ay, Year)	Death ARWYDE Birthplace (State or Foreig Country) Virginia	<u>/</u> n
rland ow at		Usual Residence of Decedent  10a. State 10b. County		I Oc. City, To	wn or Location	1				10d. Inside Cify Limits	3
ne Mary Ba-f sh otified	Director	MD Anne Aru	nde1	Glen	Burnie					1X Yes 2 □ No	>
with the	Dire	10e. Street and Number 7420 Zacary Lane			10	f. Zip Code 21061			10g. Citizen of Wha	t Country?	
ite, INIALYIAILU ZIZIO-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		}		spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - / Black, \	American Indian, White, etc. White	
vithin 72 houne. han "naturale Medical E	Completed	15. Decedent's Ed (Specify only highest gra	ucation		(Give kind of life. DO N		tion uring most of wor	king	16b. Kind of Busin		
lar ylailu ZIZ 2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	Be Co	17. Father's Name (First, Middle, Last)		(	Cab Dri		18. Mother's Nan	ne (First, Middle	, Maiden Surname)	tation	—
Tar yrallu 2 should be file and Mental H is marked oth aumatic even	To B	Preston Hippeard					Virgini				_
t and 2 sh t and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (1) Lisa Patton/Daugh	**	19		ress <i>(Street a</i> McInti Ridge,			er, City or Town, Sta	te, Zip Code)	
Datumore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	20b. Place cemet Sunse Memor	of Disposition tery, cremator et Viev rial Ga	(Name of y or other place I rdens	3-6-	Date 08	20c. Location - City Woodstock	, VA	
partit. Departit. Imports any Inj		21. Signature of Funeral Service Licen	Menu						r Funeral tock, Virg		
Physician // Medical Examiner bulksician and street private is the purial-transit	edical Examiner	23a. Part1. Enter the disease, or compance, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a Due to (or as a ded.	OVA consequence LVA consequence	FRUCT e of): Su FP e of):				urrest,	Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal dea		pic pregnancy er (specify)			23d. Date o	f delivery Day Year	
w requires that been signed b	by	Part II. Other significant conditions of	ontributing to death but	not resulting	in the underly	ing cause give	n in Part I.			te to the cause of death?  Probably 4 Unknow	n
VICAL THE LAW RESCRIPTION TO SECRETIFICATE HAS DEC	Completed							24a. Was auto perfe 1 Yes	psy prior dear	re autopsy findings availabler to completion of cause of th? Yes 2 □ No	Ð
yslciar yslciar is certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient	2 ER/C	Outpatient 3[	DOA Othe	26. Place of Dear: 4 □ Nursing H		one) idence 6 □Other (	Specify)	_
Attending Physician: The streath.  rector: After this certificate haby the funeral director, page	Certification: 1	27. Manne of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		(ear)	. Time of Injury M		at ? ′es 2 □ No	28d. Describe	how injury occurred		
Ital or Att Its after de ral Direct lled in by	Certific	4 Homicide determined	building, etc.	(Specify)				City or To	wn, State)	or Rural Route Number,	
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	yslcian: To the best of nIner: On the basis of e and manner state	xamination a	ge, death occi and/or investig	urred at the tim ation, in my op	e, date and place inion, death occu	e, and due to the urred at the time	e cause(s) and manne , date and place, and	er as stated. I due to the cause(s)	
To the within the vithing the comp	Me	29b. Signature and the of certifier	× 25	nis		29c. License	040		200 Date signed (A	o 24 200	8
7		30. Name and eddress of person who	completed cause of dea	th (Item 23a	) (Type, Print)	e Gl	5199 en B	wowe	ms:	20161	
Sta Regist	ate rar	31. Date filed (Month, Day, Year).	008 32. Registrar		Span	W.					

		For State Registrar	State	of Maryla	-	artment			d Mental I	Hygie Reg.	00	0.0	00	073
F111 3		Decedent's Name (First, Middle	e, Last)						2. Date o	f Death	(m)	UU-	3. Time of	Death
Physicia	_	FREIDA GAY HIGG	INC						Month			Year		М
/Medic Examin		4a. Facility Name (If not institution		number)		4b. City.	Town, or I	Location of De	MARCI eath	1 1/,	4c. County (	of Death	7:26	Р
LAGIIIII	ici	UPPER CHESAPEAKE				BEL					HARF			
Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under	1 Year	If Under 24 h				9. Birthp	lace (State o	r Foreian
Director		226.46.1901	1 □ M 2 💢 🛪		Yrs.	Months	Days	Hours IV		, <i>Day</i> , Ye	ar) 3,1937	Coun	vartry) VA	
р		Usual Residence of Decedent		70		1			140412	DUIT I	3,1337			
arylan show ed at		10a. State 10b. County		10c. C	City, Town or Lo	ocation						1	0d. Inside Ci	
e Ma a-f s	cto	MD ANNE	ARUNDEL	GI	LEN BURNI	ΙE							1 ☐ Yes	2 □ No XX
filed within 72 hours after death with the Maryland Hygiene. Hygiene, than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	Director	10e. Street and Number				10f. Zip	Code			10g.	Citizen of W	hat Coun		
th wi		368 MARLEY NECK R	D.			2	1060				USA			
deal sms	Funeral	11. Marital Status	12 Was D	ecedent Ever in I	U.S. 13.			spanic Origin?	(Specify Yes o	r No-	14. Race		an Indian,	
after or Ite		1 ☐ Never Married 2 ☐ Marr	ied 1 TY	Forces?		1 ☐ Yes X			derio Hican, etc.	)		k, White,	etc.	
ral";	by	3 Widowed 4 Divorced	Year o	r Dates:		ILI TES A	<b>n</b> ∟ INO	Specify:			Specify:		ITE	
within 72 ho jiene. r than "natul the Medical	Completed	15. Deceden (Specify only higher		ed)	16a. Dece	dent's Usua	Occupa	tion	working	168	. Kind of Bus	siness/Ind	dustry	-
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er th	5	12			BIL	LING S	PECIAL	LIST			MEDICAL			
be file d oth event	Be (	17. Father's Name (First, Middle,	Last)					18. Mother's I	Name (First, Mic	ddle, Mai	den Surname	9)		
should that Ment is marked umatic e	ျှ	CANEY TURNER						GERTIE	IOWA					
12 should be filed within hand Mental Hygiene. 7 is marked other than traumatic event, the Me		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address	(Street al	nd Number or	Rural Route N	ımber, C	ity or Town, S	State, Zip	Code)	
ages 1 and 2 and of Health at 1 it item 27 is or other tra	, [	PAMELA O'CONNOR	D	AUCHTER	1728	EDHIN I	DR. BE	ELAIR						
of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	. CD		Place of Dispo cemetery, cre-	osition (Nam matory or o	ne of ther place	,)	Date	200	Location - 0	City or To	wn, State	
Pages nent of int: If its		4 □ Donation 5 □ Other (S			XVIEW CR			1	CH 20, 20	08	BALTIM	ORE. 4	iD Cir	
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licersee	0	2:	2. Name and	d Address	s of Facility						
o a m be		K CRECORY FIN	6	NO1				IOME, P.A S CLEN I	A. BURNIE, M	D 210	61			
9		23a. Part1. Enter the diseate, shock, or heart failure. List	1								•		Approximate Interval Bet	e
Dharisian		shock, or heart failure. List Immediate Chise (Final	one cause o	n each line.	10.5	CA	0.40						Interval Bet Onset and D	ween Death
Physician /Medical		disease or condition resulting in death)	a		eptic	11	ock							
Examiner		Due to (or as a consequence of):  Service previous												
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ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury		`	,									
be executed ician and burial-transit	xar	that initiated events resulting in death) Last	c Due	to (or as a conse	quence of):									
be bur														
physicate by the b	dical		d											
The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c If yes	outcome pf pregr	nancy									
atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 □Liv	/e birth 2 ☐ Fe	tal death 3	Ectopic pre					23d. Date Mor		-	/ear
the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at time of iknown	death 5L	Other (spe	ecity)			_			,	
that the de led by the a	Ph	Part II. Other significant condition	ne contributing to	a dooth but not so	culting in the u	ndorbing of	uso aivo	n in Dart I	220 [	and tabas	co use contri	ibusta ta th	a aguas of d	anth 7
rest igne	5	COPD	nis contributing to	J death but not te	sularig in the u	ndenying ca	use givei	IIII Fait i.				3 Terrob		
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	BeC	25. Was case referred to medical examiner?						26. Place of I	Death (Check o					
hysic this ce al dire	0	1 Yes 2 1 No	Hospital: 1	Impatient 2	☐ ER/Outpatier	nt 3 🗆 DO	A Other	r: 4 🗆 Nursin	g Home 5□ F	Residenc	e 6 🗆 Othe	r (Specify	y)	
ig Pl	<u></u>	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin		ate of Injury fonth, Day Year)	28b. Time o Injury	f 21	Bc. Injury Work?	at	28d. Descr	ibe how i	njury occurre	ed		
ath. or: Af	atio	2 ☐ Accident investig	jation	.o., 22y , 54.,	,,	м		es 2 □ No						
Atte	ific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be ined 28e. Pla	ace of injury - At h	home, farm, str	eet, factory	office		28f. Locatio	on (Stree Town, S	t and Numbe	er or Rura	l Route Num	ber,
al or	Certification:			mamy, etc. (opeo					City of	rown, o	iaie)			
bours hours inera y fille		29a. Certifier 1 Leertifyin	g Physician: To	the best of my kn	nowledge, deat	h occurred	at the time	e, date and pl	ace, and due to	the caus	e(s) and mai	nner as st	tated.	
the Ho hin 24 the Fu	edical	(Check only 2 ☐ Medical one)	Examiner: On the and m	e basis of examin anner stated.	nation and/or in	vestigation,	in my op	inion, death o	ccurred at the t	me, date	and place, a	and due to	the cause(s	:)
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifie	r .	-		ì	License			29d.	Date signed	(Month,	Day, Year)	
		Il lusa	. Ile	()	J		000	16342	-0	M	wch	17	2008	
6	-	30. Name and address of person		ause of death (Ite	em 23a) (Type						/ (	111		
		Zubair Khai	1	500	upper (	ha wa	aleo	Drive	Bel Ai	r.n	nD 21	014		
Stat	te	31. Date filed (Month, Day, Year)		egistrar's Sigr	nature	2		_,,,-	300 141	1 **				
Registra		MAR 2 0	2008	Merce .	K So	BULL S								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 15 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner GENESIS HOMEWODA 6000 BELLINA AVE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year BACTIMORE
If Under 24 Hrs. 8, Date of Birt BALTIMONE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 80 Director March 10, 1928 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 TXYes 2 □ No Director with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be ns 23a o must be 6000 Bellona Avenue 21212 USA Funeral ral", or items ? Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 "natural", or Specify:Black 1 ☐ Yes 2 ☑ No <u>ک</u> 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working unk life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0,12) College (1-4or 5+) t of Health and Mental Hyg If Item 27 is marked other or other traumatic event, t 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Lucas / Guardian 10 N. Calvert Street; Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important; If any injury or Mount Zion Cemetery 03/19/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Early the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dehydrahan 1295 /Medical Due to (or as a consequence of): Examiner Anorwia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed ( agnitive Dys furcha the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending properties for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknowr been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ (neummin 1 Tes 2 No 3 Probably 4 Unknown Completed CHF 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 1□ Yes 2⊡No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 → 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No spital or Attend nours after death. neral Director: / 2 Accident 6 ☐ Could not be determined 28e. Place injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

within 24 hours a the Hospital 2

State Registrar

N 31. Date filed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

KlOPSZ

Charles St 32 Registrar's Signature

29c. License number

4202

D31291

Tomas -

29d. Date signed (Month, Day, Year)

3/17/08

21284

			For State Registrar	State of Marylar		artment of F		-	giene Reg. No. 2	08975
	Physic	an	1. Decedent's Name (First, Middle, La	,				2. Date of De		3. Time of Death
· Control	/Medi Exami	cal	GLORIA M.  4a. Facility Name (If not institution, given STELLA MARIS		BEIN		r Location of Death	MARCH	18,20 4c. County	
	Funeral Director		5. Social Security Number 6. 5 212-28-8710  Usual Residence of Decedent		76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 1-12-	y, Year)	Birthplace (State or Foreign Country)     MARYLAND
	Maryland a-f show	ctor	10a, State 10b. County	IMORE 10c. C	ty, Town or Lo		SVILLE			10d. Inside City Limits 1 □Yes 🏋 No
	with the	I Dire	10e. Street and Number 10102 WOODLAKE	DRIVE		10f. Zip Code	21030		10g. Citizen of V	Vhat Country?
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I're Modical Evaninar must be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - American Indian, k, White, etc.
Maryland 21215-0036	d within 72 hagiene. Ir than "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired CAFERTE	during most of work d)	ing		siness/Industry  MORE COUNTY  IC SCHOOLS
land	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last JAMES	MARKIEWICZ			18. Mother's Name	e (First, Middle,	Maiden Surnam	
	1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than kther traumatic event, Ing Mg		19a. Informant's Name/Relationship (WALTER C. HESS				and Number or Run		er, City or Town,	State, Zip Code) 21030
Baltimore,	Pages 1 and the neut of He nut; If item ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Hemovai from State		osition (Name of matory or other place VALLEY	MEM 3-2	Date 1 – 0.8		City or Town, State
Balti	permit. Pages Department of Important; If i any Injury or once.		21. Signature of Funeral Service Lice		22	2. Name and Addre	SACO AVI	CH/ROS	EDALE I	UNERAL HOME
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause on each line.  a. <b>DEMENTIA</b> Due to (or as a consec		ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Ļ	cate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unisease or injury that initiated events resulting in death) Last	b. Due to (or as a consect  C. Due to (or as a consect  d.						
O. Box 6	e death certifi the attending I ted for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 TNo 9 □ Unknown	23c. If yes, outcome of pregn 1  Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	☐Ectopic pregnand ☐Other (specify)	э <b>у</b>		23d. Dat	e of delivery nth Day Year
ds, P.	iires that th signed by t d be detach		Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause giv	ren in Part I,			ibute to the cause of death?  3 ☐ Probably 4X Unknown
Vital Records,		Completed by						24a. Was	an 24b. V	Vere autopsy findings available rior to completion of cause of leath?  ☐ Yes 2 ☐ No
of Vita	Physic this ce ral direc	:To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie		4 LI Nursing Ho	me 5 Resid		er (Specify) HOSPICE
Division of	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	1 X Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Hormicide 5 ☐ Could not be determined	( <i>Month, Day, Year</i> ) n	Injury ome, farm, str	M 1□	Yes 2 □No		Street and Number	er or Rural Route Number,
	Hospital 24 hours a Funeral I	Medical Co		nysician: To the best of my kni miner: On the basis of examin						
	To the I within 2 To the I complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number			(Month, Day, Year)
	//		30. Name and address of person who DR TARIO MAHMOOI				IMONIUM,	MD 2109		

DHMH 17 Rev 1/2001

Registrar

MAR 2 0 2008

2:34 а.ш.

MARCH 18, 2008

GLORIA HESSELBEIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day March 17, 2008 10:00 A Charlene Α. Hartman 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Timonium
oder 1 Year | If Under 24 Hrs. 215 Belmont Forest Ct. # Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Hours Min. Months 1 ☐ M 2 🛱 F Jan. 21,1934 74 Yrs New York 215-32-3010 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 215 Belmont Forest Ct. #407 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 【No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Howlin Mervyn J. Corrigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 215 Belmont Forest Ct. # 407 Timonium, MD 21093 Charles R. Hartman/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) March 18, 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Metro Crematory 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Bryan Approximate Interval Betweer Onset and Deatl caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. F ter the disease, or complications that shock, or heart failure. List only one cause or Immediate pause (Findisease or condition Due to (or a) a consequence of): resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part | Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 22200 3 Probably 4 ☐Unknown Att ial Mallon 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No ahom o 24a. Was an Non-Hod autopsy perform 2 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending

be executed burial-tran physician the as use atter for u signed by the and be detached t Ö م Records, peen page 2 s has this certificate Division or Vital After al or Attending Is after death.

**Physician** 

/Medical Examiner

> Examiner Physician/Medical ģ Completed within 24 hours after deau...
>
> To the Funeral Director: Aft

Be

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Certification:

Medical

State

Registrar

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination of the property of the management of the medical Examination of the management of the medical Examination of the management of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the medical Examination of the m

Baltimore, Maryland 21215-0036

the 2

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ature and title of certifier

2 Accident

3 Suicide

29a. Certifier

29b. Sig

4 Homicide

Robert Donnegan 6569 31. Date filed (Month, Day, Year)

MAR 2 0 2008

investigation

determined

6 ☐ Could not be

N. 32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

UNCOLOGIST

Charles Street Baltimore, MD 21204

М

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00056919

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THY//18 per Nr. 38/7,3/26/08 WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HAMILTON Month Year Physician 0300 M DERNARD 03 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Woodward Estates Bowie 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Days Yrs. Director 481 28 2902 79 June 13, 1928 Independence, IA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14997 Health Center Drive 20716 United States "natural", or items 23a dical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ă Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Manager Telephone 18. Mother's Name (First, Middle, Maiden Surname)
Norton
Ruth Morton 17. Father's Name (First, Middle, Last) Be Bert Hamilton ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 is any Injury or other trac Mary L. Hamilton (Wife) 14997 Health Center Drive, Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) March 29,2008 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Victor Memorial Cemetery Victor, 1A 5234/
22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sepride Licensee MOO 25 7 Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final an **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician a Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 6 Sther (Specify) ALF 1 ☐ Yes 🌠 No ဥ 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident after death. To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number D 21438 March 19, 2008. 445 DEFENSE HIGHWAY ANNAPOLISMDING mcera Name and address of person who completed cause of cath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAR 2 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02160 State of Maryland / Department of Health and Mental Hygiene Damian D. Isabelle Certificate of Death 1- For State Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month March 17, 2008 0954 hrs বা Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. Country) Director 1 V M Yrs 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Ves 2 No items 23a or 28a-f show ust be notified at once. Mor Director hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ra Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? Never Married 2 Married Yes 5 Yes 2 V No specify: f Yes. Give Year Divorced 'natural". \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 heart of Health and Mental Hygiene. nt of Health and Mental Hygiene. it: If item 27 is marked other than other traumatic event, the Medical 18 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type, Print) timore, MD 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition or other place) Cremation 3 1 V Burial 2 Removal from State Donation 5 Other Specify: ä e and Address of of Funeral Service Licenses Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line **Medica** Cardiac Arrhythmia Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Cardiomegaly Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and AMENDED 23a,b,27 per ME g878 4/22/08 amh Physician/Medical physician a the burial -X UNPENDED The law requires that the death certificate be Box 68760. 23d, Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Fetal death Live birth e attending for use as t past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown à Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an this certificate has been a director, page 2 should prior to completion of cause of autopsy death? performed? , page 2 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 V Yes ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending within 24 hours after death. To the Funeral Director: in by the Accident Investigation 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 18, 2008 O.C.M.E. my 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2008 Registrar

DHMH 17 Rev 1/2001 OCME 2006

amend #20b Per FH C8 Certificate of Death 2008 Andre Antonio Jones 1- For State Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 15, 2008 **Medical Examiner** 2242 hrs ANDRE ANTONIO JONES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreigh ARY LAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 214-27-6347 1 X M 2 F 18 12/05/1989 Country) Yrs Usual Residence of Deceden any 10a State 10b County 10c. City, Town or Location 10d Inside City Limits MD N/A BALTIMORE CITY 1 X Yes 2 No or 28a-f show death with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2918 ALLENDALE ROAD 21215 USA items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes If Yes, Give Yea Yes 2 X No specify: Specify: BLACK 3 Widowed 4 Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ninjury or other traumatic event, the Medical Exit. Elementary/Secondary (0-12) 72 College (1-4 or 5+) 9TH UNEMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KEVIN JONES Be SHAUNTA NICOLE MURRAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) m APT219a. Informant's Name/Relationship (Type, Print) ဥ 5426 LYNVIEW AVENUE, BALTIMORE, MD 21215 SHAUNYA N. CARTER / MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Hen tery or other place) 1 X Burial 2 Cremation 3 Removal from State OLEY CROSS CEM. 3/22/08 GLEN BURNIE, MD Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Pary . Enter the disease, or complications that caused the dear Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death a. Gunshot Wounds (2) of Head and Torso Initiate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Other Nursing Home 5 Residence 6 DOA this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Mar 15, 2008 1 2210 hrs Natural Yes 2 ✔ No Director: Pending 24 hours after death. 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town, State) 2901 Garrison Ave., Baltimore, Md determined 4 V Homicide (Specify) Parking Lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the 1 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 16, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Ruth Ann Johns March 3008 17 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT Agnes HEALTheare BALTIMOTE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 21, 19 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖫 F Days Hours Min. 219 86 3630 Director 52 Yrs. 1955 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Exercities. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7849 Americania Circle Apt. 102 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9th College (1-4or 5+) Clerk Retail Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Johns Isabelle Sunstrom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 19a. Informant's Name/Relationship (Type, Print) Isabelle Johns / Mother 719 Maiden Choice Ln. Apt. BR514 Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 03/18/2008 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the or lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical A Johns IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetat death 3 ☐ Ectopic pregnancy in the past 12 months? Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 þ 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 100 or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 P/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel or within 24 hours aft To the Funeral Di completely filled in artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) H62862 March 17,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aton Ave, Baltimore, mD 21209 32 Registrar's Signature State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day MURIEL RUTH 2008 6:00 A. M KREIPL March 16, 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4017 Lyndale Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 9, 1922 Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 💢 F Yrs. 85 214-14**-**3595 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1¶Yes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4017 Lyndale Avenue 21213 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Court Clerk State of Maryland 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Weller Nellie Tress

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

135 Regester Avenue Baltimore, Maryland 21212

Date

2. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc.

6500 York Road Baltimore, Maryland

**Physician** /Medical Examiner

certificate be executed

attending physician

the use

ō

detached

page 2 certificate |

this funeral

the Funeral Director;

2

I or Attending F after death. After

Hospital 24 hours

Box 68760

Records, P.O.

Division or Vital

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

show

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

the Medical

Baltimore, Maryland 21215-0036

12 should be filed w h and Mental Hygier 7 Is marked other th

f Health a

permit. Pages 1 Department of H Important; If ite any injury or ot

Director

by Funeral

Completed

Be

and

Mitchell-Wiedefeld Funeral
6500 York Road Baltimore

23a. Part1. Enter the fiseach, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RDIAL INFARCT Due (or as a consequence of): SCHEMIC equentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No

5 Other (specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gdns. 3-20-08

Examine Physician/Medical þ Completed မ

Certification:

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 7BRILLATION

9 I Inknown

4☐Pregnant at time of death

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy
performed?

1 Yes 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier

19a. Informant's Name/Relationship (Type. Print)

4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee

(Son)

1 Burial 2 □ Cremation 3 □ Removal from State

Gary Kreipl

20a. Method of Disposition

9 Unknown

29d. Date signed (Month, Day, Year)

20c. Location - City or Town, State

Month

Dav

Timonium, Maryland

21212

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

For Caw-Cick, MD 6830 the Spital Dr #104 Baltinary MD 21237

State Registrar

MAR 2 0 2008

31. Date filed (Month, Day, Year)

29a, Certifier

Theresa

		For State Registrar	State of M	arylan		artment of F		d Mental Hy	/giene	008	08982
Physicia /Medic		1. Decedent's Name (First, Middle THERESA	J.		ľ	RAFT		2. Date of Do Month	eath Day i G	2008	3. Time of Death
Examin	er	4a. Facility Name (If not institution FRANKLIN Scale) 5. Social Security Number 214-20-5044	6. Sex 7. Ag	je (In yrs. l	ast birthday)	4b. City, Town, c	edal	eath  Cars. 8. Date of Bi	4c. Cour	nty of Death	MOFE
Director		Usual Residence of Decedent  10a. State  10b. County	1□M 2 <b>½</b> F	9	Yrs.		l lodio   ivi	8-12-	-1916	MAR	YLAND Od. Inside City Limits
the Maryli 28a-f sho otified at	ector	,	ALTIMORE	l co. o.c,		SEDALE			40. 0%		1 □Yes 2 No
s 23a or nust be n	Funeral Director	5902 KENWOOD				10f. Zip Code	21237			J.S.A	•
nours after de ural", or item	þ	11. Marital Status  1 □ Never Married 2 □ Marri  **Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	o- 14. R B	ace - Americ lack, White, cify: W	
is 5, Wall y lail of LILID-0000  I and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. If the AT Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	College (1-4or 8	5+)	16a. Deced (Give life, L	lent's Usual Occup kind of work done DO NOT use retire HOMEMA	during most of v d)	vorking	16b. Kind of OWN	HOME	dustry
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Mental Hygiene.	To Be (	17. Father's Name (First, Middle, I		RNEC			18. Mother's N	lame (First, Middle		_{ame)} SUPIK	1
VICALLY A 2 Shou Lh and M 7 is mar traumat	-	19a. Informant's Name/Relationsh THERESA DeCAF	nip (Type. Print)				and Number or	Rural Route Numb	ber, City or Tow	n, State, Zip	Code)
Pages 1 and 2 hent of Health and: If item 27 inty or other tra		20a. Method of Disposition 1	3 ☐Removal from State	20b. Pl	ace of Dispo	KENWOO sition (Name of natory or other plan	i	Date	20c. Location		21237 wn, State
permit. Pages 1 and Department of Heali Important: if item 2 any injury or other once.		4 Donation 5 Dother (Section 21. Signature of Funeral Service t		GA:		OF FAI Name and Addre	ess of Facility C		BALTI SEDALI SEDALI	E FUN	, MD ERAL HOMI 21237
bur bur	ical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. First or death of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause	a. End Due to (or as  b. Due to (or as  c	a consequ	ence of):	Dem	, .		arrest,		Approximate Interval Between Onset and Death
ath certifica	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy	у			Date of delive	ery Day Year
uires that the de	þ	Part II. Other significant conditio	ns contributing to death b	ut not resu	lting in the ur	nderlying cause giv	en in Part I.		tobacco use co		e cause of death?
: The law requir cate has been si page 2 should	Completed							24a. Was - auto perfo 1∐ Yes		o. Were autop prior to cor death? 1 ☐ Yes	psy findings available npletion of cause of 2  No
ysician: Th iis certificate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatie	ent 2 🗆 E	R/Outpatien	t 3 DOA Oth	or:	eath <i>(Check only o</i> Home 5 ☐ Resi		ther (Specify	<i>(</i> )
3 ~ ~ C	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation of he	y Year)	28b. Time of Injury			28d. Describe	how injury occi	urred	·
ital or At ars after d ral Directilled in by		4 ☐ Homicide determine	ned 28e. Place of Injuries	c. (Specify,	)			City or To	wn, State)		l Route Number,
he Hosp in 24 hor he Fune ipletely fi	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	g Physician: To the best of Examiner: On the basis of and manner sta	f examinati	rledge, death on and/or inv	estigation, in my c	me, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) and i	manner as st e, and due to	ated. the cause(s)
To To	Σ	29b Signature and title of certifier	and .	141	$\sim$	29c. Licens	e number		29d Date sign	ed (Month, i	Day, Year)
V		30. Name and address of person v				,	San	0.5 0.2	211	1m -1	21235
Stat Registra	е	Dr Mada Char 31. Date filed (Month, Day, Year) MAR 2 0 2	don-Borra 37 Registra 2008	ar's Signati	ure	SEP .	30,000	e uk i	isali o	md	21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** pole man Month march JONIA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Harbor HospitalCenter N/A COLC. MM. JOHN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🕱 F Hours 212 44 9092 63 Director 06/04/1944 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at show Director 1XYes 2□No Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or 1349 Cambria Street death v Funeral 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Retail Clerk 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Jenkins Georgie Pullen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Wilder / Daughter 2nd Floor Baltimore, MD. 21225 4007 - 3rd Street Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important; If it any Injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 03/19/2008 | Baltimore, Maryland 21. Signature Fign ral Service Linesee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** WKIDUL /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2风No 24a. Was an certificate has autopsy perform Dulmodam Miserso 2 No funeral director, as case referred the enca Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Tes ို 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After (Month, Day Year) 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

completely filled in by the

State

Registrar

Hamoves

rson who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** March 19, Mary Eileen 2008 /Medical Lansella 3:24 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arden Courts Assisted Living Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛣 Yrs 216-24-4673 Director 79 May 23,1928 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1911 Merritt Boulevard 21222 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Board and 2 should be filed within ealth and Mental Hygjene. n 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) of Education 12 years 2 years Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William McQuade Frieda Lorenz or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai Paula Dixon Daughter 1911 Merritt Boulevard, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 22, 1X Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Mary Cem. 2008 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE EMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, francisco Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of) Records, P.O. Box 68760, ate has been signed by the aftending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Voar 4☐Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTE Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5×100 Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division or funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 ☐ Homicide within 24 hours a 1 x ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation in my calculated death occurred. Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charles Street Suck 209 State Registrar

MISSI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #1 per Phy G877 3/20 Certificate of Death Rec. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death J<u>os</u>eph Charles Lhotsky Time of Death Day Year **Physician** Month LhotsKu 0.2 2002 1353 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air, Maryland
If Under 1 Year | If Under 24 Hrs. | 8.
Months | Days | Hours | Min. | Upper Chesapeake Medical Center Harford Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 214-30-4135 05/14/1931 Maryland 76 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2005 Waverly Drive 21015 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify Specify: Be Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Worker Rosedale Federal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Lhotsky ဂ Henrietta Marie Herman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy T. Lhotsky (wife) 2005 Waverly Drive - Bel Air, Maryland 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/21/2008 Baltimore, Flatyland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee €. assaln 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Athenselectu /Medical Due to (or as a consequence of) Examiner Emphisemo Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trar Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1. ZYes 2 □ No Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Hospital 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO 36487 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive - Bel Air, Maryland 21014 Steven Bentman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 0

# LED.WELL) WoodrowBaltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State Registrar	State of	Maryland /	_	artment of H		nd Mental Hy	giene	08	089	986
		1. Decedent's Name (First, Middle	e, Last)					2. Date of D	eath	V	3. Time of	Death
Physicia /Medic		Woodrow Ledw	re11					MARCH	$\overset{Day}{1} \overset{I}{1}$	2008	10:48	$\mathbf{P}^{M}$
Examin		4a. Facility Name (If not institution	n, give street and numb	er)		4b. City, Town, or	Location of E	Death	4c. Coun	ty of Death		
	27	GREATER BALTIN				TOWSON If Under 1 Year	I I I I ada a O.4	U= 1		TIMOR		
Funeral Director		5. Social Security Number 241–18–7605	6. Sex 7. 11X M 2□F	Age (In yrs. last b	Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of Bi (Month, D Nov 11	av. Year)	9. Birth Coul West	place <i>(State</i> o ntry) : VA	r Foreign
w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	cation				1	10d. Inside Cit	ty Limite
Maryla f sho ed at	ō	MD			timo						11X Yes	
the N 28a- notifi	rect	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cou	ntry?	
n with	Ö	1801 Wentworth	Road				234		USA			
deatl	Funeral Director	11. Marital Status	12, Was Decede		13.	Was Decedent of H	ispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Ra	ace - Ameri		
or Ite		1 Never Married 2 Marr		□ No		Tes, specify oubs	Specify:	- dello filoan, etc.)	Spec	ack, White,	olack	
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hould d Mer marke matic	၉	19a. Informant's Name/Relations	hin (Time Print)	10	h Mailin	a Address (Street	and Mumbar	or Rural Route Numl	or City or Town	- Ct-t- 7:	- 0	unk
nd 2 sulth an 27 is i		Tom Smith/frie		19	ib. Mailli	g Address (Sileel )	and Number C	or narar noute mumi	er, City or Tow	n, State, Zı	o Code)	-
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	j	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Sta	comot		sition (Name of natory or other plac	re)	Date	20c. Location	- City or To	own, State	
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Depa Impo any I	- 4	21. Sign ture of Funeral Service	Wade / 1	rector	1.0	ate Anato		ard 655 W.	. Baltin	nore S	Street	
		23a. Part1 Enter the disease, or shock or heart failure. List	complications that cau	sed the death. Do	not ent	er the mode of dyin			ırrest,		Approximate Interval Bet	e ween
Physician		Immediate Cause (Final disease or condition	15	12620	9 €	2 C	NNO	29		- 1	Onset and D	Death
/Medical Examiner		resulting in death)	Due to (or	as a consequence	e of):							
200	<u>.</u>	Sequentially list conditions, if any legaling to immediate	b. Due to for	as a conse luence	off:							
uted d ansit	Examiner	Cause (Disease or injury										
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the d by the ached	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□Unknow		3,_	Other (apecity)						
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ician certifi ector	Be	25. Was case referred to medical examiner?	Hoenital:	<b>₽</b> *		Othe		Death Check onl	one			
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th. :: Afte	tion	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Month,		Injury	28c. Injun Work	k? Yes 2∐No		now injury occi	anca		
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Ital or rs after al Dir led in	Certification:		Danding.	, etc. (opecity)				City or To	wii, State)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  Certifyin	g Physician: To the be Examiner: On the basi and manner	s of examination a	ge, death ind/or inv	occurred at the ting estigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time	cause(s) and r date and place	manner as s e, and due t	stated. to the cause(s	i)
To the within To the comple	Me	29b. Signature and title of certifie		~ ' a.	1	29c. License	number		29d. Date sign	ned (Month,	Day, Year)	7
		) (		E ZIO	Vir	a por	410	10	3	-15	-08	5
		30. Name and address of person	who completed cause of	of death (Item 23a)	(Type, I	Print)	10	CITI	wich	\\.AA	1212	OL,
C	20	31. Date filed (Month, Day, Year)	For WII	istrar's Signature		12-CNO	161	21,10	w tow	( 000)	7	
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urt Emile Lawr		1- For State	of Maryland / De C	partment of certificate of		d Mental H		200	12 11292
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)					2. Date of Deat Month	eg No. ( )     h Day Year	3. Time of Death
/ledical Exami	ner	Kurt Emile Lawrence			0. 7	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	March 14,	2008	1637 hrs
		4a. Facility Name (if not institution, give 19 Post Office Avenue #10		4	Laurel	Location of Death	1	4c. County of Dear Prince Georg	
Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year			th(MM/DD/YYYY) 9. B	
Director		213 30 0371	M 2 F 46	Yrs.	World's Day	S Hours Will	10/26/1		ountryMaryland
any		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Location	on				10d. Inside City Limits
Aaryland 28a-f show 1 at once	or	Maryland Prince Geor	ges l	_aurel					1 Yes 2 χ No
he Maryland or 28a-f sho	Director	10e. Street and Number	0.4		10f. Zip Code		10	0g. Citizen of What Co	untry?
with th	eral D	19 Post Office Ave, #1 11. Marital Status	12. Was Decedent Ever in			spanic Origin? (S		USA - 14. Race - Ame	rican Indian, Black,
r death or iten	Fune	1 X Never Married 2 Married	Armed Forces?  1 Yes 2 X No	0		i, Mexican, Puerto	Rican, etc.)	White, etc.	
hours after "natural", Examiner	by	3 Widowed 4 Divorced  15. Decedent's Education (Specify onl	If Yes, Give Year or Dates: v highest grade completed		Yes 2 X No	specify: tion (Give kind of	work done	Specify:	White //Industry
6 72 hou in "nat cal Exa	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life	DONOT use ret	ired)	lconics	
OO3	omp	17. Father's Name (First, Middle, Last)		Microso				Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be C	John Paul Lawrence					et L. You		
	٢	19a. Informant's Name/Relationship (Ty John Paul Lawrence- fa	•			et and Number or		nber, City or Town, Sta	e, Zip Code)
e, MD and 2 shc Health and item 27 is		20a. Method of Disposition	20	b. Place of Disposi	tion (Name of ce	metery,	Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 4 Donation 5 Other Specify:	Removal from State Me	crematory or oth etropolitan	erplace) Crematory	Marc	ch 17, 200	8 Alexandria	a, Virginia
3alti ermit. Departm mports njury o		21. Signature of Funeral Service Licens		22. Na F1 e	ame and Address	of Facility Home, IN	С.		
Physician		23a. Part I. Enter the disease, or compli		760 ath. Do not enter th	1 Sandy Sp e mode of dying,	ring Rd.,	Laurel, Mor respiratory arre	1D 20707 est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on eac Immediate Cause (Final disease a. C	th line. Cirrhosis of liver						Between Onset and Death
Aanimer		or condition resulting in death)	ue to (or as a consequenc	e of):					
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e be executed ysician and burial - transi		d							<del>-</del>
50, nte be execut nysician and e burial - tra	Medical	IF FEMALE:	AMENDED  23c. If yes, outcome of p	regnancy				23d. Date of delive	or)
Sox 6876 leath certificat e attending phy	cian/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time of	2 Fet	al death 3	Ectopic pregn	ancy	Month	Day Year
Box e death o the atter ed for us	S	1 Yes 2 No 9 Unknown	9 Unknown	oth 5 Oth	er (Specify)				
b.O. that the red by t	by Phy	Part II. Other significant conditions	contributing to death but n	ot resulting in the ur	nderlying cause	given in Part I.		obacco use contribute t	o the cause of death?
ds, P.C equires that een signed i	ted						24a. Was		autopsy findings available
e law re e has by ge 2 shc	Completed	· · · · · · · · · · · · · · · · · · ·						rmed? death?	
tal Rec cian: The l certificate l ector, page	Be Co	25. Was case referred to medical			26.Place	of Death (Check	1 Yes	2 No 1 🗸	res 2 No
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Visic or Atte fter dea Director in by th	Certification:	2 Accident Investigation 3 Suicide 6 Could not b	28e Place of Injury - A	At home, farm, stree	t, factory, office t	ouilding, etc.			Rural Route Number, City
Division spital or At thours after dineral Direct	Cert	4 Homicide determined	(Specify)				or Town, S	tate)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:	n: To the best of my know On the basis of examination						
To To	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
		Klyprie The	Knell		O.C.	M.E.		March 15, 2008	
8		<ol> <li>Name and address of person who co Margarita Korell MD. Ass</li> </ol>	ompleted cause of death (I sistant Medical Exan		enn Street, B	altimore, MD	21201		
S	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature /		,		<del></del>	
Regist	trar	MAR 2 0 200	O Stallarin .	1 Span	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fb 9877 3-20-08 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 17, Mary 2008 Lishka 5:45 at /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 174-12-8934 93 1 □ M 2 🔀 F Director 01/08/1915 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Frederick Frederick 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 990 Waterfird Drive, 21702 rai", or items 23a ( Examiner must b USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mpage Wife (First, Middle, Maiden Surname) Be John Dombrowski <del>a</del> Petrowski ပ 19a. Informant's Name/Relationship (Type. Print)
Joseph Lishka / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5905 Charleigh Circle, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State St. Ignatius Cemetery 3/25/2008 4 □ Donation 5 □ Other (Specify) Scott Twp., PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East FortAvenue, Baltimore, MD 21230 East FortAvenue, Baltimore, MD 21230 Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONGESTI UE HEART **Physician** FAILURE disease or condition resulting in death) 10 DAY. /Medical Due to (or as a consequence of) Examiner HEANT tateizioscle autic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: Se 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy for Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ġ P 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? after death. Certification: 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

10

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MAR 2 0

JULIO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEINGEN

2008

MD-

32 Registrar's Signature

110

DHMH 17 Rev 1/2001

29c. License number

BAUGHMANS Lone Suite 140 - FREDERICH

29d. Date signed (Month, Day, Year)

21702

Registrar

State

29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Ursula Naylor Eland McCracken 2008 March 9:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 501 West University Parkway Apt.E1 Baltimore 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 31, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1942 Hours 1□M 2 F 66 045-34-3738 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 XYes 2 ☐ No Director N/A Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 501 University Parkway Apt. E1 21210 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes ¾☐ No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry artment of Health and Mental Hygiene. ortant: if item 27 is marked other than Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Executive Director Museum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael John Naylor Eland Ursula Brockwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are important: if item 27 is any injury or other trau Edward McCracken, Husband 501 University Parkway Apt. E1 Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 03/18/08 Baltimore, Maryland 21. Signature of Funeral Service bigensee ²Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 110104115 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of a Examiner requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Hospital: 2 No 2 TER/Outpatient 1 Tyes 1 Inpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

15

State Registrar

31. Date filed (Month, Day, Year) MAR 20

BLAKELEY

address of person who completed cause of

29b. Signature and title of certifier

30. Name and

ORCEANS STREET SUITE 11/16 BACTIMORE, MARYLAND 21231

ath (Item 23a) (Type, Print)

29c. License number

00064099

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0602 AM 03 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HUSPITAL WestminsTER CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Y 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 63 MARYLAND Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ARROLL 1 Yes 2 □ No Director MO INKSBURG 10e. Street and Number 10g. Citizen of What Country? USA 2104 GEORGIA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PERINTENDENT CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARTIN ELSIE DYKE ဥ 19a. Informant's Name/Relationship (Type Print) PROTHER-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES T. BEZOLD AVE 20 WESTMINSTER MO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 12008 CORRAINE 122 4 Donation 5 Dother (Specify) WOODLAWN, MD 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility INZUMBRUN FIT & MON. Co-6028 SYKESVILLE ROMB ELDELDBURG MO 21784 23a. In the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🥕 attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? es 2LINo 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 30 DOA ၉ 1 Inpatient 2 ER/Outpatient Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Hown Stad Woods Nau 1

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

2008

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

	5. Social Security N 216-16-4		6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 84	last birthda Yrs.	y) If Under Months	1 Year Days	#Under Hours	Min.	8. Date of Bi (Month, D	av, Yea	r)	Cour	ntry)_	te or Foreign
1	Usual Residence of			04				L1	- 1	37-20-	1923	·	McL	rylan	ia
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ne l	11. Marital Status		12. Was Ded Armed F	cedent Ever in U. orces?	.S. 13	B. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori ın, Mexicar	gin? (Spec	cify Yes or N Rican, etc.)	D-		- Americ , White,	an Indian etc.	1
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To Be Completed by Funeral Director	17. Father's Name George	Eb1	ا م					18. Mothe		(First, Middle eline :			e)		
Ε.	19a. Informant's Na				19b. Ma	iling Address	(Street	and Numbe		Route Numl			State. Zic	Code)	
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ŀ	21. Signature of Fu			M00053		22. Name ar									ome at
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	23a. Part1. Enter the shock, or hea	he disease, o	r complications that t only one cause on	caused the deat										Approxir Interval	nate Between
19	Immediate Cause ( disease or conditio	(Final	_	ementi									27	Onset ar	nd Death
	resulting in death)			(or as a conseq										4	
Sequentially list conditions											144	ears			
mine	cause. Enter Unde Cause (Disease or that initiated events	injury	₹ 500.0	(or as a conseq	acrice or).										
Exa	resulting in death) I	Last	Due to	(or as a conseq	uence of):										
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eted by Physician/Medical Examiner	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	1□Live	birth 2 Feta nant at time of d	I death 3	□Ectopic p □ Other (s _i						Mor		Day	Year
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ed by	Skin	ulcer	`\$							10	Yes	2□ No	3□ Prob	oably 4	dnknown
plet										24a. Was		24b. V	Vere auto	psy findin	igs available of cause of
Com										perf	ormed?	d	eath?	2 No	o. ouddo OI
3e (	25. Was case refer examiner?	red to medica	al					26. Place	of Death	(Check only					
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_:uc	27. Manner of Deat 1 ☑ Natural	h 5 🗆 Pendir	28a. Date	of Injury oth, Day Year)	28b. Time Injury	of 2	28c. Injun Work	/ at c?	2	8d. Describe	how inj	ury occurre	ed		
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3. Time of Death

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	Physici /Medic		Terry Parker				Marc		2008	5:51 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. Cour	nty of Death	
			Harbor Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last	birthdav)	If Under 1 Year	If Under 24 H	Irs. 8. Date of B	irth	9. Birth	place (State or Foreign
	Funeral Director		5. Social Security Number $8.8 \text{sex}$ $1.20-66-1670$ $1.2 \text{ F}$ $1.3 \text{ M}$ $2 \text{ F}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4 \text{ Sex}$ $1.4  Sex$	Yrs.	Months Days	Hours M	Irs. 8. Date of B (Month, D 6/06)	71955	MAR	YLAND
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	the N	Director	10e. Street and Number		10f. Zip Code			10g. Citizen o	of What Cou	ntry?
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215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show nt, the Medical Examiner must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No   f Yes, Give   Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or Nierto Rican, etc.)	В	Race - Ameri Black, White, cify: BLA	etc.
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VItal	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?		t 3DDOA Othe	ar:	Death (Check only			
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	Vith To t	Σ	29b. Signature and title of certifier		29c. License			29d. Date sig		-
			Atalia MO		REST			Marce	15	2003
	6		30. Name and address of person who completed cause of death (Item 23)  A - ESTAPILLA 300/5. 11	ano	Print) ver St.	Tra 1				
T.	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature		c					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Yvon Dorothy Pucelli 8:45 a M March 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2408 Marbourne Avenue, Apt. Baltimore n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗗 F 214-44-4079 65 Director Maryland Oct 06, 1942 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a, State 10b. County 10d. Inside City Limits show notified Maryland n/a Baltimore 1 ¥ Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be or Pages 1 and 2 should be filed within 72 hours after death with inent of Heatilt and Mental Hygiene. and the first it fem 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be nury or other traumatic event, the Medical Examiner must be not 2408 Marbourne Avenue, Apt. 2C 21230 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: þ White 3 Midowed 4 Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Not self sufficient 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chris Pappas Emma Handley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Kimberly Y. Hutchinson / Dau. 14 Mountain Green Circle, Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 3/19/08 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death allock Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): 1S Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) 2**.** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature of certifier 29c. License number 26656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 DUNDFOUS Roll SEVERN JORGE COLDERO 31. Date filed (Month, Day, Year) 32. Registrar's Signatu 0 2008

Registrar

08-02154	
Jason Peck	

ison Peck	State of Maryland / I	Department of Hea  Certificate of Dea		_	201	08 0899
Physician/ ledical Examine	Registrar  1. Decedent's Name (First, Middle,Last)  Jason	Peck	<del></del>	2. Date of Death	Day Year	3. Time of Death 0644 hrs
, b	4a. Facility Name (If not institution, give street and number) 2704 Bparman Avenue	4b. City,	Town, or Location of Death		4c. County of De	
Funeral Director			der 1 Year If Under 24Hrs	_	1 (MM/DD/YYYY) 9.1 9,1985	Birthplace (State or eign Country) Maryland
'n	Usual Residence of Decedent	Dc. City, Town or Location				10d. Inside City Limits
and show any nce.	10a. State	Rosedale				1 Yes 2 No
the Maryland a or 28a-f sh tified at once	10e. Street and Number		p Code	10	g. Citizen of What C	
th the 1 23a or notified	1207 Berk Avenue		21237		USA	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year	If Yes, spec	lent of Hispanic Origin? (Sjify Cuban, Mexican, Puerto		14. Race - Am White, etc	
hours after a natural "  Examine ed by	I or Dates: 15. Decedent's Education (Specify only highest grade compl	eted) 16a. Decedent's Usua	l Occupation (Give kind of orking life. DO NOT use ret		16b. Kind of Busines	
5-0036 ed within 72 hour lygiene, other than "naturb M dical Exam	Elementary/Secondary (0-12) College (1-4 or 5+)  9 years	Laborei	· ·	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Food Indi	ietry
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical TO Be Comple	17. Father's Name (First, Middle, Last)	Lawren	18.Mother's Name	e (First, Middle, M		БСГУ
2121 uld be fil Mental J marked c event,	David Michael Peck Sr.  19a. Informant's Name/Relationship (Type, Print)	10h Mailing Addres	Bonnie	Lee Brau		ato Zin Code\
MD 21 and 2 should lith and Me and 27 is ma aumatic ev	Bonnie Lee Peck mother		k Avenue, Ros			21237
2	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State	20b. Place of Disposition (Na crematory or other place Oak Lawn Ceme	e).	.CII ZZ,	20c. Location - City	
Baltimore, permit. Pages 1 ar Department of Hee Important: If itel Injury or other tr	4 Donation 5 Other Specify:	50.000		8008	Dundalk, M	
Baf permi Depar Impo	gnature of Funeral Service Lice see	V 7110 S	Address of Facility Lly Funeral F Sollers Point	Iome Of I Road, I	Dundalk,P. Dundalk.Mo	A. 21222
Physician	3a. Part I. Enter the sase, or complications that cause of failure. List only one cause on each line.	e death. Do not enter the mode	of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical -xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Heroin intoxi					Death
	Sequentially list conditions, b					
nsit Examiner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated	uence of):				
	events resulting in death) Last  Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the co	uence of):			<del>,</del>	
ian a	X UNPENDED AMENDED 23a,2	7,28a-f per ME g8	77 3/26/08 amh			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Functal Director: After this certificate has been signed by the attending physic tely filled in by the funeral director, page 2 should be detached for use as the bur all Certification: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome 1 Live birth	2 Fetal death		ancy	23d. Date of delive Month	very Day Year
). Box the death of by the atter ached for us	1 Yes 2 No 9 Unknown 4 Pregnant at tir	ne or death 5 Other (Sp	ecify)			
P.O. es that the igned by be detach	Part II. Other significant conditions contributing to death b	out not resulting in the underlyin	ig cause given in Part I.			to the cause of death?  Probably 4 Unknown
Records, P.C  The law requires that freate has been signed t , page 2 should be deta  Completed by				24a. Was a		autopsy findings available to completion of cause of
Recol The law cate has page 2 sl				perform 1 Yes 2		
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?  Hospital: 1 Inpatient	2 ER/Outpatient 3	26.Place of Death (Check		Residence 6 🗸 0	ther: Scene
of Ving Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Phys	1 ✓ Yes 2 No Impatient  27. Manner of Death 28a. Date of Injury (Month, Day,Yea		28c. Injury at Work?		ow injury occurred	THE . Scene
ivision of or afterding Phear death.  Director: After the finey the funeral lin by the funeral thincation: T	Natural 5 Pending Found 3/17	/08 Found 6:30am	1 Yes 2 X No	Unknown		
Division of Vital Records, ospital or Attending Physician: The law require hours after death.  Inneral Director: After this certificate has been si y filled in by the funeral director, page 2 should be Certification: To Be Completed	3 Suicide 6 XX Could not be determined 28e. Place of Injur	ry - At home, farm, street, factor	y, office building, etc.	28f. Location (S or Town, St Limore		Rural Route Number, City an Avenue
Di To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier (Check only one)  2 Medical Examiner:On the basis of examinand manner stated.	nowledge, death occurred at the		due to the cause	e(s) and manner as s	
- F F 5 8	29b. Signature and title of certifier	29	Oc. License number		29d. Date signed (	
	30. Name and address of person who completed cause of dea	ath (Item 23a)	O.C.M.E.		March 17, 200	-
	Donna M. Vincenti, MD Assistant Medical	Examiner 111 Penn	Street, Baltimore, N	1D 21201		
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's MAR 2 0 2008	Sonature				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician BARET MARIH 2000 /Medical 5 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NORTHWES RANDAUS TOWN BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 11, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 JyF Yrs. Maryland 212-01-6978 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifiled at 1 ☐ Yes 2 🗓 No Director Baltimore Woodlawn Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Gwynn Lake Drive Funeral 21207 United States of America death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Clerk 42 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Elizabeth Klein Pages 1 and 2 should ပ Charles Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other traignes. (Son) Barry E. Price 8870-A Spiral Cut Lane, Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremi 03/20/08 Granite, Maryland 21163 Granit Presbyterian Cem. 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service License 8728 Liberty Road, Randallstown, Maryland 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Immediate Cause (Final **Physician** CADDIOVASCULAR THEROSCLERUTIL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titlated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2□ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Marrier of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 Tes To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examinaer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signatu/e and title of centifier

MILHAEL

5401 ROTHKIN OUD LOURT RUAD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

RANDALISTON

29d. Date signed (Month, Day, Year)

15, 2000

21133

Usual Residence of Decedent

10b. County

300 Seward Avenue

Anne Arundel

12. Was Decedent Ever in U.S. Armed Forces?

10a. State

Directo

Maryland

11. Marital Status

10e. Street and Number

For	/land / Department of Health and IV	nental Hygi	ene	
State Registrar	Certificate of Death	Reg	g. No.	0. 0006
. Decedent's Name (First, Middle, Last)		2. Date of Death	man die co.	3. Time of Death
Edith Roe	lummer	Month March	16 2008	
a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	eath
6602 Church Street	Sykesville		Carrol	_1
. Social Security Number 6. Sex 7. Age 1 M 2√2 F	n yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 09/07/19		Birthplace (State or Fore Country) aryland

10f. Zip Code

21225

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10c City Town or Location

Baltimore

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

U.S.A.

1 ☐ Yes 2 ☑ No

**Funeral** Director

**Physician** /Medical Examiner

death with the Maryland ns 23a or 28a-f show must be notified at

item 27 is marked other than "naturai", or items other traumatic event, the Medical Examiner man

3altimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division or Vital Records, P.O. Box 68760, C burial-transi the ate has been signated by a should b To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A

Funeral 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 9 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert John Roe Clara R. Dukes ဠ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Plummer / Son 300 Seward Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 03/21/2008 | Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (A as a consequence of): disease or condition resulting in death) Advance Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 2 Fetal death 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ Orteuperum 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Nother \( (Specify) \) Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina 29a. Certifier death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ng/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 30. Name and address of person into co death (Vern 23a) (Type, Print) 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001

Registrar

MAR 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Patricia Joanne Payne 9:00 P M March 11 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director <u>578 54</u> 5304 Aug 31, 1942 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ural", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2**Y**No Maryland Prince George Temple Hills Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8601 Temple Hill Road 20748 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23; ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 TVNo If Yes, Give 1 A Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 🏋 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James McGowan Geraldine Stalbird ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other tr once. James F. McGowan (Brother) 990 Grace Road, Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Cedar Hill Cemetery March 17, 2008 Suitland, Maryland 22. Name and Address of Facilib Lee Funeral Home, Inc 6633 01d 21. Signatur Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findlngs available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform 2 No to medical 25. Was funeral director, Be e referred 26. Place of Death Check onl one examiner' ToF Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 27. Manuer of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No s after death 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours at To the Funeral D Hospital

> State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type,

29b. Signature and title of certifier

MOT

29c. License number

		1	For State Registrar	State of Maryland		artment of H		nd Men		ene 00	8	08999
			1. Decedent's Name (First, Middle, Last)			-			late of Death	Day \	rear	3. Time of Death
	ysicia Iedic	al	Zelda RO						irch 17	7, 2008		7:00 P M
	amin	_	a. Facility Name (If not institution, give			4b. City, Town, or				4c. County of		1817
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Baltimore, Maryland 21213-0035 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or items 23s or 28s-1 show	auma		19a. Informant's Name/Relationship (T)		19b. Mail	ng Address (Street Goldleaf	and Number	ror Rural Ro	hesda.	City or Town, S	State, Zij 817	p Code)
and and m 27	her tr	r	Robert Rosenberg,	20h P	lace of Disp	osition (Name of		Date	_	Oc. Location - (		own, State
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	n. Do not er	ter the mode of dy	ng, such as	cardiac or re	spiratory arre	st,		Approximate Interval Between
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Exam	iner	_	Sequentially list conditions, if any, leading to immediate	b. Parkinson's		ase					-	7 16413
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. Box 68 death certifica	or use	an/k	IF FEMALE: 23b. Was decedent pregnant in the past 12ynonths?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3	□Ectopic pregnanc	у			23d. Date Mor		ivery Day Year
The dea	hed fo	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□ Unknown	eath 5	Other (specify) _						
P.O.	be detached f	F.	Part II. Other significant conditions co	ontributing to death bul not res	ulting in the	underlying cause g	ven in Part I.		23e. Did tob	acco use contr	ibute to	the cause of death?
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Division of or Attending effer death.	y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm,	treet, factory, office	•	281	Location (Si		er or Ri	ural Route Number,
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Hospitel	completely filled in by the fu		29a. Certifier 1/1 Certifying Ph	ysician: To the best of my kniner: On the basis of examin	owledge, de	ath occurred at the investigation, in my	time, date ar	nd place, and ath occurred	d due to the c at the time, d	ause(s) and ma late and place,	inner as and due	s stated. e to the cause(s)
the H	plete	ledical	one)	and manner stated.			nse number			9d. Date signe		
To the within 2	000	Σ	29b. Signature and title of certifier	7/Krs haus	2		21977	1		March		
			30. Name and address of person who	completed cause of death (the	m 23a) (Tvo	a Print)						
(0			Robert L. Rosent	erg, M.D., 27	30 Uni	versity	3 <b>1v</b> d.,	W. #:	310, W	neaton,	MD	20902
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State of Maryland / Department of Health and Mental Hygiene amend #7 Per FH G877 3/20/98 rullicate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:10 P M Rowe, Sr. March 15, 2008 Beto /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charles 12276 Wendy Lane Waldorf If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months Alabama 421 42 9849 72 March 9, 1936 Director Usual Besidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 No Director Maryland | Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number United States 20601 12276 Wendy Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 TYYes 2 □ No 1954 If Yes, Give Year or Dates: 1974 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. <u>ک</u> American 3 Widowed 4 Divorced 1974 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Safety Ret Fire Fighter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roosevelt Rowe Annie Heard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20601 12276 Wendy Lane, Waldorf, MD Nancy Rowe (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) March 20, 2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Your X Hans Alexandria Ferry Road, Clinton, MD 20735 MO0257 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as a consequence of) Examiner 166Kinson Discase Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2(7) No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 27. Manner of Dark 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. hin 24 hours after death the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed, (Month, Day, Year) 29c. License number 29b. Signature and title of certifie DOOG480 Survetts R1 # 307 (linten, m) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sham rotel 750 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 0 2008 Registrar